INSTITUTE FOR STRESS CONTROL
All information will remain confidential
Please fill out and bring with you to your appointment.

PATIENT INFORMATION (Please print legibly)

Patient Name:_____ Date:_____
Home Address: _____ City: _____
State: _____Zip:_____ Home phone: ( )_____
Work #:( )_____Cell #: ( )_____
Email: _____Birthdate:_____
Social Security Number: _____- _____ - _____
Male Female Minor / Single / Married / Divorced / Widowed / Separated
If patient is a student, name of school: _____
Patient/Parent's Employer: _____
Patient's Email: _____

RESPONSIBLE PARTY (if different from patient)

Name: _____Relationship: _____
Address if different from above: _____
City: _____ State: _____Zip: _____
Home phone:( )_____Work: ( )_____Cell: ( )_____
Email: _____Birthdate:_____
Social Security Number: _____- _____ - _____

As the responsible party, I understand that I am responsible for any balance due on this account.

Signature of Responsible Party: _____**Date**: _____

INSURANCE INFORMATION (Primary)

Policyholder's Name:_____Birthdate: _____
Social Security Number: _____-_____-_____Work Phone: ( )_____
Employer: _____ Insurance Company:_____
Member ID (required):_____**Group #** (required): _____
Is authorization required: NO YES Authorization #: _____

***Do you have secondary insurance*? YES NO** If yes, please complete below:
Policyholder's Name:_____Birthdate:_____
Social Security Number: _____-_____-_____Work Phone:( )_____
Employer:_____ Insurance Company:_____
Member ID (required):_____Group # (required):_____
Is authorization required: YES NO Authorization #: _____