stresscare
behavioral health
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Director

# Patient Information Sheet

**Patient Information**

**NAME:** _____ **DATE:** _____
**SOC SEC NO:** _____ **DATE OF BIRTH:** _____
**ADDRESS:** _____
**City:** _____ **State:** _____ **Zip Code:** _____
**PH# Home:** _____ Can we leave a message at this number? **YES NO**
**Work:** _____ Can we leave a message at this number? **YES NO**
**Cell:** _____ Can we leave a message at this number? **YES NO**
**CURRENT EMPLOYER:** _____
**Address:** _____
**MARITAL STATUS:** ____ **Married** _____ **Single** _____ **Divorced** ____ **Widowed**
Whom may we contact in the event of an emergency? _____
Relationship: _____ Phone Number: _____

## Communication Authorization

I authorize the following person/people to communicate with StressCare regarding canceling or scheduling appointments and/or billing and insurance issues. I understand that this does not authorize these individuals to have information about my psychotherapy.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

## Insured/Responsible Party Information

**NAME:** _____ **DATE:** _____
**SOC SEC NO:** _____ **DATE OF BIRTH:** _____
**ADDRESS:** _____
**City:** _____ **State:** _____ **Zip Code:** _____
**PHONE NUMBERS:** **Home:** _____ **Work:** _____
**CURRENT EMPLOYER:** _____
**Address:** _____

**(OVER)**

3840 Woodley Road, Ste. A * Toledo, Ohio 43606 * Phone: (419) 531-3500 * Fax: (419) 531-1877

## INSURANCE INFORMATION

**Primary Insurance:** _____

Name of Insured: _____

Identification Number: _____ Group Number: _____

**Secondary Insurance:** _____

Name of Insured: _____

Identification Number: _____ Group Number: _____

## For Workers' Compensation Patients

**Industrial Claim Number:** _____ **Date of Injury:** _____

**Employer Name:** _____

**MCO Name:** _____

**MCO Phone Number:** _____

## BASIC MEDICAL INFORMATION

**Current Health Problems (if any):** _____

_____

_____

**Symptoms:** _____

_____

**Allergies:** _____

_____

**Medications You Are Taking:** _____

_____

**Who is your family doctor?** _____

**Who may we thank for referring you to us?** _____

## ASSIGNMENT OF BENEFITS FOR TREATMENT

*I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf, or to myself. I understand that I am financially responsible for all charges not covered by my insurance.*

_____ _____

Patient or Authorized Signature Date

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