OC-PSYCHIATRIST, INC.
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INSURANCE INFORMATION

Client Name:_____ Date of Birth: _____
First Last

Client Address:_____
Street City State Zip

Client Phone: Home:_____ Work:_____ Cell:_____

SS#_____ Gender: _____ Marital Status:_____

Policy Holder Name:_____ Date of Birth:_____
First Last

Relationship to Client (spouse, child, parent, other): _____

Policy Holder Address:_____
Street City State Zip

Policy Holder Phone: Home:_____ Work:_____ Cell:_____

Policy Holder Date of Birth:_____ Policy Holder SS#_____

Policy Holder Gender:_____Policy Holder Marital Status:_____

Policy Holder's Employer: _____

Name of Insurance Company:_____

Type of Policy: (HMO, PPO, Indemnity, EAP, other): _____

Member ID #:_____ Group #:_____

Phone number for benefits verification:_____

Does your insurance company have mental health benefits? _____

Deductible Amount:_____ Copay:_____

Number of sessions covered by insurance company?_____

Name of Primary Care Physician: _____

Primary Care Physician Phone Number: _____