Capital District Behavioral Health, PLLC

Patient Information

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

Address: _____ _____ _____ _____
Street *City* *State* *Zip*

Phone Numbers: Home _____ Work _____ Cell _____

SS Number: _____ Sex M / F Marital Status _____

Employer: _____ Occupation:_____ Student? Y / N

Primary Care Physician: _____ Who referred you to us? _____

PRIMARY Insurance Policy Information

Name of Insurance Plan _____

Patient's ID # (include prefixes/suffixes) _____ Group/Plan # _____

Name of Policy Holder _____ Relationship to patient _____ Sex M / F
Last *First*

Date of Birth _____ Address _____ _____ _____ _____
Street *City* *State* *Zip*

Phone Numbers: Home _____ Work _____ Cell _____

Employer _____

SECONDARY Insurance Policy Information

Name of Insurance Plan _____

Patient's ID # (include prefixes/suffixes) _____ Group/Plan # _____

Name of Policy Holder _____ Relationship to patient _____ Sex M / F
Last *First*

Date of Birth _____ Address _____ _____ _____ _____
Street *City* *State* *Zip*

Phone Numbers: Home _____ Work _____ Cell _____

Employer _____