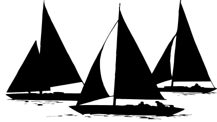

Bay Pointe Behavioral Health Service, Inc.

Child ● Adolescent ● Adult Psychiatry

PATIENT INSURANCE BENEFIT INFORMATION

Date___________________________

Patient ____
Last First Initial

Address____
Street City State Zip Code

Home Phone _________________________________Cell Phone________________________________

SS#_________________________ Sex: M F Date of Birth _______________ Age________________

Student Status: __Part Time __ Full Time __Non-Student E-Mail ________________________________

Marital Status: **S W M D -** Spouse's Full Name____
(If applicable)

Known Medical Conditions________________________________Allergies__________________________

Previous Surgeries/Illnesses ____________________Medications___________________________________

Reason for Initial Visit____

Referred to this office by ____

Responsible Party/Parent's Name (if different) ____

Address (if different)____
Street City State Zip Code

Home Phone__________________________ **Relationship to Patient**_____________________________________

Emergency Contact Person_____________________________**Phone**___________________________

Parent or Guardian's name (of Minor if applicable) _______________________________________

Occupation/Student__________________**Employer/School**________________**WorkPhone**_______

********************************Your Insurance***************************************

Primary Company______________________________ Address____

Policy #______________________________ Group #____________________ Phone___________________________

Subscriber____________________ DOB ______________ Relationship to Subscriber_____________________________

Secondary Company____________________________ Address_______________________________________

Policy #______________________________ Group #_____________ Phone_____________________________________

Patient/Responsible Party **x**___________________________________Date________________

Witness____ Date________________

(PLEASE COMPLETE ENTIRE PAGE. THANK YOU)