Cara Marks ARNP

Client Registration Date_____

(for office use) DSM 5 _____

Name:_____ age:_____ Sexual identification:_____

Address:_____ Social Security Number_____

City:_____State:_____Zip_____ Date of Birth:_____

Preferred phone number to reach you and/or leave a message_____

Person responsible for bill_____Relationship_____

Address_____phone_____

_

Social security number_____Employer_____Workphone_____

Spouse/Partner/Contact person_____ phone _____

Employer_____Occupation_____

Address:_____

Insurance/Health Care Information:

Subscriber_____ Date of Birth_____

Subscriber Number_____ Group Number_____

Primary insurance company_____

Address_____phone_____

Managed care company_____phone_____

Address_____

Secondary insurance company_____ phone_____

Subscriber_____ Date of Birth_____ _Subscriber number_____

Address_____

Managed care company_____

Address & phone_____

Primary Care Provider_____ phone _____

authorization number for referral_____