1305 Wiley Road, Suite 125
Schaumburg, IL 60173

Today's Date: ______________________ Clinician's Initials __________

PATIENT INFORMATION

NAME: ____
EMAIL: ____
DATE OF BIRTH: ____
HOME ADDRESS: ____
(including city & zip)____
PHONE (Home):_______________________________________
(Work):_______________________________________
(Cell or Pager):_________________________________
EMERGENCY CONTACT: _________________________*phone*________________

How did you hear about us? ____

Insurance Information: *All patients must fill out this section. Please provide us with a copy of the front and back of your insurance card.*

INSURANCE NAME: ____
INSURED NAME: ____
RELATIONSHIP TO THE INSURED: _____________________________________
INSURED DATE OF BIRTH: ____
INSURANCE GROUP NUMBER: ____
INSURED ID NUMBER: ____

EAP Information: *Please complete this section if you are utilizing your Employee Assistance Program benefits.*

EAP Company Name: ____
EMPLOYER: ____
AUTHORIZATION NUMBER: _________________________________
NUMBER OF SESSIONS AUTHORIZED: ________________________