Jan 2017 Rev
ProActive Behavioral Services

PATIENT INFORMATION	DATE:
Name:	Sex: Age:
Date of Birth:	SSN:
Address:	Is this a worker's compensation case? **YES / NO**
City/State/Zip:	List of Allergies to Medication:
Cell Phone:	List of Current Medications:
Home Phone & Work Phone Numbers: H: W:	Marital Status: **SINGLE / MARRIED / DIVORCED / SEPARATED/ WIDOWED**
Email:	Name of Spouse:
PARENT INFORMATION (if client is under 18)	
Name:	Relationship to Client:
Address: (if not same as above)	Date of Birth:
City/State/Zip:	Primary Care Doctors Name/Phone/Fax:
Home Phone:	Would you like PBS to share information with your primary care doctor? (circle) YES NO
Cell Phone:	If you agree to have PBS share health information with other Doctors please see PBS staff for a Release of Information Form.
Insurance Information:	
Insurance Company:	Please provide PBS staff with a copy of your insurance card
Primary Carrier's Name:	Primary Carrier's Birth Date: SSN:
ID #	Group #

In order to submit a claim for payment to me for services covered under your policy, I must have your authorization to release medical information to your insurance carrier and assign benefits otherwise payable to me to the Doctor or Group indicated on the Claim. I understand that in the event insurance does not cover the expense that I will be responsible for paying the balance in full within 90 days after insurance declines to pay. Late fees and collections costs can be added to my bill.

SIGNATURE:________________________________ DATE: ________________________________