DEMOGRAPHIC AND INSURANCE INFORMATION

FOREST VIEW HOSPITAL

PATIENT INFORMATION (PLEASE PRINT):

Legal Name: _____ Date Of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Social Security #: _____ Marital Status: _____ Race: _____

Employer/School _____

Phone - Home: _____ Alternate #: _____

RESPONSIBLE PARTY (if patient is a minor or has a guardian): ☐ Adult : Self-Responsible

Legal Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Social Security #: _____ Relation To Patient: _____

Phone – Home: _____ Alternate #: _____

INSURANCE INFORMATION: ☐ Copy of Insurance Card(s) provided ☐ Copy of Rx coverage provided

PRIMARY INSURANCE CO: _____ ID#: _____

Employer/Group Name: _____ Group #: _____

Policy Holder's Name: _____ Soc. Sec. #: _____

Birthdate of Insured: _____ Relation to Patient: _____

SECONDARY INS. CO: _____ ID#: _____

Employer/Group Name: _____ Group #: _____

Policy Holder's Name: _____ Soc. Sec. #: _____

Birthdate of Insured: _____ Relation to Patient: _____

PRESCRIPTION COVERAGE: _____ ID#: _____

Ph# _____ Preferred Pharmacy_____

Emergency Contact : _____ Relation To Patient: _____

Phone: _____ Alt Phone: _____

I hereby authorize Forest View Psychiatric Hospital to communicate with my insurance company in order to verify benefits, obtain authorizations and all correspondence related to the submission and payment of my claims.

Signature: _____ Date: _____