THE TAUB GROUP
Treatment for Pain and Addiction

## PATIENT INFORMATION

| Date | Referring Physician | Family Physician |
|---|---|---|
| | | |

| Patient's Last Name | First Name | Middle or Maiden |
|---|---|---|
| | | |

| Street Address | City | State and Zip |
|---|---|---|
| | | |

| Home Phone<br>( )<br>Cell Phone<br>( ) | Social Security No. | Date of Birth | Age |
|---|---|---|---|
| | | | |

| Sex<br>____M ____ F | Marital Status<br>___S ___M ___W ___D | Spouse's Name<br><br>Phone ( ) |
|---|---|---|
| | | |

| Employer Name | Employer Phone<br>( ) |
|---|---|
| | |

| Emergency Contact Name | Contact Phone<br>( ) | Relation |
|---|---|---|
| | | |

## INSURANCE INFORMATION (Please provide a copy of insurance card)

| Primary Insurance Co. Name | Policyholder's Name | Policyholder's Date of Birth<br>_____/_____/_____<br>mm dd yyyy |
|---|---|---|
| Insurance Claims Address | City/State/Zip | Insurance Co. Phone<br>( ) |
| Insurance ID Number | Group Name and/or Number | Employer Plan<br>____ Y ____N |
| Secondary Insurance Co. Name | Policyholder's Name | Policyholder's Date of Birth<br>_____/_____/_____<br>mm dd yyyy |
| Insurance Claims Address | City/State/Zip | Insurance Co. Phone<br>( ) |
| Insurance ID Number | Group Name and/or Number | Employer Plan<br>____ Y ____N |

I understand that my insurance will be filed for me and that benefits will be paid directly to The Taub Group. I understand that I may be asked to assist in obtaining proper payment from my insurance company and agree to do so. I understand that if I do not have insurance coverage that payment is expected at the time of service and I am solely responsible for all charges incurred. I also understand that I will be charged $25 for any appointments that I have not given 24 hour notice.

_____ _____

Signature of Patient/Responsible Party Date