AZCounseling, PLLC

Patient Insurance Information

Patient's name: _____ **DOB:** _____
First MI Last

Patient's SS#: _____ **Sex:** □ Male □ Female

Patient's address: _____
Street

_____
City State Zip

_____ _____ _____
Home phone number Cell phone number Work phone number

Subscriber ID #: _____ **Group #**_____

Patient's status: □ Single □ Married □ Other
□ Employed □ Full-time student □ Part-time student

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other

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Insured's name (if different from patient): _____ **DOB:** _____
First MI Last

Insured's SS#: _____ **Sex:** □ Male □ Female

Insured's address: _____
Street

_____
City State Zip

_____ _____ _____
Home phone number Cell phone number Work phone number

Insured's employer: _____

Insurance plan name: _____

Insurance policy group # _____

Authorization #: _____

Secondary health benefit? □ NA □ Yes (complete below)
Insurance plan name: _____
Insured's name: _____
Insurance ID#: _____
Insurance policy group #: _____