Today's Date

COPELAND AVE COUNSELING

PATIENT INFORMATION

First Name

Last Name

Street & #, PO Box, RR#, Apt # (Where you receive your mail)

City | State | Zip

Home Phone

Work Phone

Date of Birth			Age	Marital Status					Male
Mo	Day	Yr		M	Single	Sep	D	W	Female

Social Security Number

Employer Name & Address

Date of Injury or Onset of Symptoms			Is this a work related injury or illness?	Yes	No
Month	Day	Year	Is this an auto accident related injury?	Yes	No

RESPONSIBLE PARTY INFORMATION (IF NOT PATIENT)

First Name

Last Name

Street & #, PO Box, RR#, Apt # (Where you receive your mail)

City | State | Zip

Home Phone

Work Phone

Date of Birth			Relationship to Patient
Mo	Day	Yr	

Social Security Number

Employer Name & Address

MEDICARE ID NUMBER	Is Medicare Your Primary Insurance?	NYS MEDICAID ID NUMBER	Do You Have A Medicaid HMO?	If yes, please list the information below
	Yes ☐ No ☐		Yes ☐ No ☐	

Primary Insurance (If not Medicare)

Name

Address Where Claims Are Mailed

Insurance Phone #

GROUP NUMBER

POLICY IDENTIFICATION NUMBER

Policy Holder's Name

Policy Holder's Date of Birth			Male
Month	Day	Year	Female

Policy Holder's Social Security Number

Patient's Relationship to Policy Holder | Co-Pay Amount

Employer Name if Through Employer

Secondary Insurance (Including Medicare Supplemental)

Name

Address Where Claims Are Mailed

Insurance Phone #

GROUP NUMBER

POLICY IDENTIFICATION NUMBER

Policy Holder's Name

Policy Holder's Date of Birth			Male
Month	Day	Year	Female

Policy Holder's Social Security Number

Patient's Relationship to Policy Holder | Co-Pay Amount

Employer Name if Through Employer

Additional Insurance

Name

Address Where Claims Are Mailed

Insurance Phone #

GROUP NUMBER

POLICY IDENTIFICATION NUMBER

Policy Holder's Name

Policy Holder's Date of Birth			Male
Month	Day	Year	Female

Policy Holder's Social Security Number

Patient's Relationship to Policy Holder | Co-Pay Amount

Employer Name if Through Employer

I authorize my insurance to be paid to the provider and acknowledge that I am financially responsible for any unpaid balance(s). I also authorize the release of any information required.

Signature

SIGN HERE

SAMEDICAL\NYPT fdb