Sheryl E. Woodhouse, LMFT

23121 Verdugo Drive Suite #200
Laguna Hills, CA 92653
(949) 212-6228 / (949) 348-6943

PATIENT

Referred by: ____________________

Patient's Name: ____ Date of Birth: ____________________

Spouse/Partner's ____ Date of Birth: ____________________

Address:____ City:______________________ Zip: _____________

Patient's Home #: (_____) _______________ Work #: (_____) _______________ Cell #: (____) ___________

Spouse/Partner's HM #: (_____) _______________ Work #: (_____) _______________ Cell #: (____) ___________

Phone Numbers IF patient is a minor:

Mother's Home #: (_____) _______________ Work #: (_____) _______________ Cell #: (_____) ______________

Father's Home #: (_____) _______________ Work #: (_____) _______________ Cell #: (_____) ______________

E-mail: ____ Driver's License #: __________________________

Social Security #: _________________________ Date of Birth: _______________ Single / Married / Divorced

Employer's Name: ______________________________ Address: ____

Name of Nearest Relative:____ Relationship: _________________

Nearest Relative's Address: ____ Phone #: (____) ____________

I N S U R A N C E

Name of Insured: ______________________________________ Relationship to Patient: ______________________

Insured's Soc. Sec. #: ____________________________________ Insured's Date of Birth: _______________________

Insured's Address: ______________________________________ City: ___________________ Zip: _________

Insured's Employer: ____

Employer's Address: ____ City: ___________________ Zip: _________

Insurance Company: ______________________________________ Phone #: (_______) ____________________

Insurance Address: ____________________________________ City: _________________ State: ____ Zip: _______

Policy #: ____ Group #: _______________________________

Is there secondary insurance? ________ If so, please request a separate form for Secondary Insurance

AUTHORIZATION (Signature on File)

I authorize use of this form on all my insurance claim submissions. I authorize the release of any medical or other information necessary to process my insurance claims. I understand that **I am responsible** for my bill. I authorize Sheryl Woodhouse, MFT to act as **my** agent in helping to obtain payment from my insurance carrier(s). I irrevocably authorize payment of medical benefits directly to Sheryl Woodhouse, MFT for services rendered to me. I request payment of government benefits be made directly to Sheryl Woodhouse, MFT, who hereby accepts such assignment. I permit a copy of this authorization to be used in place of the original.

Dated: ________________________ Signature: ____

Print Name: ____

DIAGNOSIS / COMMENTS

Diagnosis: ____ ICD-9 code: ____

COMMENTS:

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P A T I E N T: ____

SECONDARY I N S U R A N C E

Name of Insured: ____ Relationship to Patient: ______________________

Insured's Soc. Sec. #: ______________________________________ Insured's Date of Birth: _______________________

Insured's Address: ____ City: ____________________ Zip: __________

Insured's Employer: ____

Employer's Address: ____ City: ____________________ Zip: __________

Insurance Company: _______________________________________ Phone #: (_______) _____________________

Insurance Address: _____________________________________ City: __________________ State: _____ Zip: ________

Policy #: ____ Group #: ______________________________________

AUTHORIZATION (Signature on File)

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Dated: _______________________ Signature: ____

Print Name: ____