Sheryl E. Woodhouse, LMFT

23121 Verdugo Dr., Suite 200
Laguna Hills, CA 92653
(949) 212-6228 / (949) 348-6944

PATIENT

Name/DOB: ______________________ Referred by :______________________

Parents/DOB (if patient is a minor):______________________

Address:______________________ City:__________ Zip:______________________

Phone No(s):______________________

Phone Numbers if minor client:
Mother HM #: (____) __________ WK #: (____) __________ Cell #: (___) ________
Father HM #: (____) __________ WK #: (____) __________ Cell #: (____) ________

E-mail Address: ______________________ Driver's Lic #: ______________

Social Security #: ____________ Date of Birth: ________ Single Married Divorced

Employer & address: ______________________

Name of Relative: ______________________

Nearest Relative's Address/Ph. ______________________

INSURANCE

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 Co:______________________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, LMFT 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:

Sheryl E. Woodhouse, MFT
26391 Crown Valley Pkwy, Suite 110
Mission Viejo, CA 92691-7309
(949) 212-6228 / (949) 348-6943

PATIENT: ______________________________

SECONDARY INSURANCE

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: ____________________________