Health Directions
North Central Behavioral Health Systems

Date___/___/____

Name:_____ Social Security #: __ __ __ - __ __ - __ __ __ __

Date of Birth: ___/___/____ Marital Status: □ Single □ Married □ Divorced □ Widowed

Home Address: _____
Street City State Zip

Home Telephone: (___)_____ Work Telephone: (___)_____

Employer's Address: _____
Street City State Zip

Spouse's Name: _____ Work Telephone: (___)_____

Employer's Telephone: (___)_____

Referral Source (doctor, phone book, website, etc): _____

Referral Address:_____
Street City State Zip

Reason for coming to Health Directions:
_____

Primary Care Physician: _____ Telephone: (___)_____

Whom May We Contact in an emergency? _____

Telephone: (___)_____ Relationship: _____

I will pay for treatment by: □ Cash □ Check □ Credit Card

Insurance Information

PRIMARY Insurance: _____ Policy No.:_____

Address: _____
Street City State Zip

Insured's Name: _____ Insured's D.O.B: ___/___/____ Effective Date:___/___/____

Insured's Social Security #: __ __ __ - __ __ - __ __ __ __ Relationship to Insured: _____

Employer's Name: _____ Copay: $_____ Deductible Amount: $_____ Met? □ Yes □ No

Annual/Lifetime Max: $_____ Pre-Certified? □ Yes □ No Benefits/Coverage: _____

SECONDARY Insurance: _____ Policy No.:_____

Address: _____
Street City State Zip

Insured's Name: _____ Insured's D.O.B: ___/___/____ Effective Date:___/___/____

Insured's Social Security #: __ __ __ - __ __ - __ __ __ __ Relationship to Insured: _____

Employer's Name: _____

Pre-Existing Clause: □ Yes □ No If yes, based on: □ Signs □ Sx □ Dx □ Tx