Clinician name: ____

Appointment date and time: ____

Patient Name: ____

Patient: Date of birth _________________________ Check one: Male ______ Female ______

Patient: Mailing address:

____

____

Patient: Tel: _____________________________ Check one: Cell____ Home____ Office ____

Patient: Email address (for confidential information):

____

INSURANCE:
Name of insurance company:

____

Member ID # (include alpha prefix if applicable): _____________________________________

Group #: ___________________________________

Primary cardholder: Name: ____

Primary cardholder: Date of birth: _________________

Relationship to patient: Check one: Self ____ Spouse ____ Child ____ Other ____

INSTRUCTIONS:

Please email the completed form and a copy or photo of the front and back of the insurance card to Heather at intake-service@hushmail.com or fax to 508-433-1871.

PO Box 33 • South Chatham, MA 02659 • Tel: 888.658.1145 ext 1 • Fax: 508-433-1871