



Father's Cell Phone _____	Mother's Cell Phone _____
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PATIENT _____ SS# _____ DOB _____
 Address _____ Home Phone _____
 City _____ State _____ Zip _____ Sex _____
 School _____ Teacher _____ Grade _____
 Emergency contact _____ Relationship _____ Phone _____
 Email _____

FATHER _____ SS# _____ DOB _____
 Address _____ Home Phone _____
 City _____ State _____ Zip _____ Marital Status _____
 Employer _____ Occupation _____
 Address _____ Work Phone _____
 City _____ State _____ Zip _____
 Email _____

MOTHER _____ SS# _____ DOB _____
 Address _____ Home Phone _____
 City _____ State _____ Zip _____ Marital Status _____
 Employer _____ Occupation _____
 Address _____ Work Phone _____
 City _____ State _____ Zip _____
 Email _____

INSURANCE COMPANY INFORMATION

Primary _____	Secondary _____
Address _____	Address _____
_____	_____
Policy # _____	Policy # _____
Group # _____	Group # _____
Policy Holder _____	Policy Holder _____
Primary Care Physician _____	Office Phone Number _____
Referring Physician or Agency _____	

I understand that I am financially responsible for payment of services received by me or my dependent(s). I agree to pay for services at the time they are received. I understand that the providers at Keystone are not contracted with insurance companies. I authorize the release of clinical or medical information to my insurance company, primary care physician and referral source or agency when needed for insurance coverage and/or payment.

Signature _____ **Date** _____