Phone: 240.237.8338
Fax: 240.237.8353
info@chesapeakesouththerapeuticgroupllc.com

Today's date:			Family Doctor:		
CLIENT INFORMATION					
Client's last name:	First:	Middle:	❑ Mr. ❑Mrs. ❑ Miss ❑ Ms.	Race: _____	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:	City:	State & ZIP Code:			
Home Phone Number: ( )	Cell Phone Number: ( )	Work Phone Number: ( )	Voicemails: ❑Yes ❑No Text Messages: ❑Yes ❑No Email:_____		
Occupation:	Employer:	Social Security Number:			
Referred to practice by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	Other family members seen here:
IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING					
Guardian's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street address:	Social Security no.:	Home phone no.: ( )			
P.O. Box:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer phone no.: ( )			

I give my permission for the minor client named above to be treated by *Chesapeake South Therapeutic Group LLC*

Patient/Guardian signature *Date*

The above information is true to the best of my knowledge. I understand that I am financially responsible for all services.

Patient/Guardian signature *Date*

IN CASE OF EMERGENCY			
Name of local friend or relative	Relationship to client:	Home phone no.: ( )	Work phone no.: ( )

NOT Intended for Litigation/ For Treatment Purposes Only

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INSURANCE INFORMATION

(Please give your insurance card to the therapist to make a copy)

Client's last name:		First:		Middle:	
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )	
Is this person a client here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:		Employer phone no.: ( )	
Is this client covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Deductible? ❑ Yes ❑ No	Deductible Amount: $_____ ❑ Per Individual ❑ Per Family Member How Much has been used towards your deductible so far? $_____				
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Chesapeake South Therapeutic Group LLC. I understand that I am financially responsible for any balance. I also authorize Chesapeake South Therapeutic Group LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date