Edgewood
A LIFESTANCE HEALTH COMPANY

CLIENT INFORMATION

CLIENT FIRST NAME	CLIENT LAST NAME	BIRTHDATE	AGE	GENDER

STREET ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY #	CELL PHONE #	HOME PHONE #	EMAIL

EMERGENCY CONTACT	RELATIONSHIP TO CLIENT	EMERGENCY CONTACT PHONE #

WHO REFERRED YOU TO EDGEWOOD?	PHONE NUMBER #	ORGANIZATION

DO YOU REQUIRE ASSISTANCE DUE TO A DISABILITY? YES _____ NO _____

IF YES, PLEASE DESCRIBE NEEDED ASSISTANCE

INSURANCE INFORMATION

IS INSURANCE BEING USED? YES _____ NO _____ IF NO, PLEASE COMPLETE SELF-PAY AGREEMENT FORM

ARE YOU COVERED BY MEDICAID OR MEDICARE? YES _____ NO _____ IF YES, PLEASE COMPLETE OPT-OUT AGREEMENT FORM

PRIMARY INSURANCE

INSURANCE NAME	EFFECTIVE DATE	MEMBER ID

POLICY HOLDER	POLICY HOLDER BIRTHDATE	GROUP #

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES (IF DIFFERENT FROM CLIENT)

FIRST NAME	LAST NAME	RELATIONSHIP TO CLIENT

STREET ADDRESS	CITY	STATE	ZIP CODE

CELL PHONE #	HOME PHONE #	EMAIL

HOUSEHOLD MEMBERS

FAMILY MEMBER NAME	BIRTHDATE	RELATIONSHIP

PHONE NUMBER	EMAIL	INSURANCE COMPANY

FAMILY MEMBER NAME	BIRTHDATE	RELATIONSHIP

PHONE NUMBER	EMAIL	INSURANCE COMPANY

FAMILY MEMBER NAME	BIRTHDATE	RELATIONSHIP

PHONE NUMBER	EMAIL	INSURANCE COMPANY

PLEASE REQUEST ADDITIONAL REGISTRATION FORMS IF YOU HAVE ADDITIONAL HOUSEHOLD MEMBERS TO LIST

I hereby authorize Edgewood to release to the above insurance companies information needed for claims reimbursement. I hereby assign, transfer, and set over to Edgewood all of my rights, title, and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me by Edgewood.

_____ _____ _____

Client Signature (18 & over) Client Printed Name (18 & over) Date

_____ _____ _____

Parent/Guardian Signature (under 18) Parent/Guardian Printed Name (under 18) Date