Pathways Alcohol and Drug Treatment Center

PATIENT INFORMATION

Patient Information Label

Please complete **ENTIRE** form by printing in BLACK INK. Please complete **front and back** of this form.

PATIENT INFORMATION

LAST NAME	FIRST NAME		MIDDLE INITIAL
STREET ADDRESS	CITY	STATE	ZIP
COUNTY	HOME TELEPHONE NUMBER	CELL PHONE NUMBER	
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS
ETHNICITY ☐ Hispanic ☐ Non-Hispanic	RACE	LANGUAGE	INTERPRETER NEEDED ☐ Yes ☐ No
EMPLOYER			
EMPLOYER STREET ADDRESS	EMPLOYER CITY	EMPLOYER STATE	EMPLOYER ZIP
WORK TELEPHONE NUMBER	EMPLOYMENT STATUS (FT/PT)	JOB TITLE	

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE			**NAME OF SECONDARY INSURANCE (if applicable)**		
POLICY NUMBER	GROUP NUMBER		POLICY NUMBER	GROUP NUMBER	
PATIENT RELATIONSHIP TO SUBSCRIBER	**If Patient is Subscriber, you do not need to complete the rest of this section**		PATIENT RELATIONSHIP TO SUBSCRIBER	**If Patient is Subscriber, you do not need to complete the rest of this section**	
SUBSCRIBER LAST NAME	FIRST NAME	MI	LAST NAME	FIRST NAME	MI
STREET ADDRESS			STREET ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
SUBSCRIBER SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	SUBSCRIBER SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX
SUBSCRIBER'S EMPLOYER			SUBSCRIBER'S EMPLYER		
EMPLOYER'S ADDRESS, CITY, STATE AND ZIP			EMPLOYER'S ADDRESS, CITY, STATE AND ZIP		

GUARANTOR OR PERSON RESPONSIBLE FOR PAYMENT ☐ Check here if Same as Patient and skip to Guarantor's Signature below to sign

LAST NAME	FIRST NAME			MIDDLE INITIAL
STREET ADDRESS	CITY		STATE	ZIP
COUNTY	HOME TELEPHONE NUMBER	CELL PHONE NUMBER		
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	RELATIONSHIP TO PATIENT
EMPLOYER				
EMPLOYER STREET ADDRESS	CITY		STATE	ZIP
WORK TELEPHONE NUMBER	EMPLOYMENT STATUS (FT/PT)	JOB TITLE		
GUARANTOR'S SIGNATURE (GUARANTOR MUST BE PRESENT)			DATE	

PLEASE COMPLETE INFORMATION ON THE BACK OF THIS SHEET

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PERSON TO NOTIFY IN CASE OF AN EMERGENCY

LAST NAME	FIRST NAME		MIDDLE INITIAL
STREET ADDRESS	CITY	STATE	ZIP
HOME TELEPHONE NUMBER	CELL PHONE NUMBER	RELATIONSHIP TO PATIENT	

NEXT OF KIN ☐ **Check here if same as Person to Notify in Case of Emergency listed above**

LAST NAME	FIRST NAME		MIDDLE INITIAL
STREET ADDRESS	CITY	STATE	ZIP
HOME TELEPHONE NUMBER	CELL PHONE NUMBER	RELATIONSHIP TO PATIENT	

PRIMARY CARE PHYSICIAN ☐ **Check here if Patient does not have a Primary Care Physician**

PRIMARY CARE PHYSICIAN'S NAME	TELEPHONE NUMBER		
STREET ADDRESS	CITY	STATE	ZIP

PATIENT SIGNATURE	DATE

PLEASE DO NOT WRITE BELOW THIS POINT

To be completed by Pathways Staff Only

WITNESS	DATE