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## **PATIENT INFORMATION SHEET**

**PATIENT NAME (First and Last):**

**DATE OF BIRTH (DOB):**

**SOCIAL SECURITY NUMBER (if you have Magellan):**

**EMAIL:**

**ADDRESS:**

**PHONE:**

**PRIMARY INSURER'S NAME:**

**PRIMARY INSURER'S DOB:**

**TYPE OF INSURANCE:**

**INSURANCE ID#:**

**INSURANCE AUTHORIZATION # (for IEHP insurance only):**

**INSURANCE PHONE:**

**CO-PAY:**

**DEDUCTIBLE:**

**REFERRED BY:**

**REASON FOR COUNSELING:**