South Bayconnect
—Treatment Center—
RECOVERY • HOPE • CHANGE

Today's Date:_____

PATIENT INFORMATION

Last Name	First Name	Date of Birth

Address	City	Zip

Home Telephone	Cell Phone	Work Telephone

Employer	Occupation	Email Address

PHYSICIAN INFORMATION

Primary Care Physician	City	Telephone Number

Referring Physician	City	Telephone Number

INSURANCE INFORMATION – **Insurance Card Must Be Presented at time of Appointment!**

Insurance Carrier	Subscriber ID Number	Group Number

Policy Holder Last Name, First	Policy Holder Date of Birth	Relationship to Client

Policy Holder Address	City	Zip

Policy Holder Employer	Policy Holder Social Sec. #	Ins. Co. Telephone Number

CONTACT INFORMATION

Person to contact in case of Emergency:

Name	Address	Relationship
Home Telephone	Cell Phone	Work Telephone

FOR CONFIDENTIAL/PRIVATE MESSAGES TO PATIENT:

Phone Number	E-Mail Address	Other