HEALTH INSURANCE INFORMATION FORM
Coastal Calm Psychiatry Associates LLC

Patient Name: _____ Date of Birth:_____/_____/_____
Today's Date: _____/_____/_____

PATIENT DEMOGRAPHICS
Full Legal Name: _____
Date of Birth: _____/_____/_____
Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Other: _____
Address: _____
Phone: _____
Alternate Phone: _____
Email: _____
SSN (Last 4 Digits): XXX-XX-____

PRIMARY INSURANCE INFORMATION

Insurance Provider: _____
Policyholder Name: _____
Policyholder DOB: _____/_____/_____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____
Policy/Group Number: _____
Member ID: _____
Plan Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Medicaid ☐ Other: _____
Insurance Phone: _____

SECONDARY INSURANCE (IF APPLICABLE)
Provider: _____
Member ID: _____
Group Number: _____

Authorization & Consent:
- I authorize the release of medical information to my insurance provider for billing.
- I understand I am responsible for any unpaid balances.

Patient/Parent Signature: _____
Date:_____/_____/_____