CORE
Psychotherapy Center

1305 Wiley Road, Suite 125
Schaumburg, IL 60173

**Today's Date**: _____ Clinician's Initials _____

## PATIENT INFORMATION

NAME: _____
SOCIAL SECURITY: _____
DATE OF BIRTH: _____
HOME ADDRESS: _____
(including city & zip)_____
PHONE (Home):_____
(Work):_____
(Cell or Pager):_____
EMERGENCY CONTACT: _____*phone*_____

***How did you hear about us?*** _____

**Insurance Information:** *All patients must fill out this section. Please provide us with a copy of the front and back of your insurance card.*

INSURANCE NAME: _____
INSURED NAME: _____
RELATIONSHIP TO THE INSURED: _____
INSURED DATE OF BIRTH: _____
INSURANCE GROUP NUMBER: _____
INSURED ID NUMBER: _____

**EAP Information:** *Please complete this section if you are utilizing your Employee Assistance Program benefits.*

EAP Company Name: _____
EMPLOYER: _____
AUTHORIZATION NUMBER: _____
NUMBER OF SESSIONS AUTHORIZED: _____