Maura Loftus
LCSW

232 West Main Street, Suite 103
Tustin, CA 92780

PATIENT INFORMATION FORM

Name _____

Address _____

City_____ Zip Code_____

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

Cell Phone(_____) _____ - _____ Other (_____) _____ - _____

Marital Status _____ Birthdate _____ /_____ /_____

Religion_____

Social Security Number _____

Insured's Name_____

Insured's Social Security Number_____

Insured's DOB _____ /_____ /_____

Insured's Employer_____

Insurance Company_____

Billing Address_____

Policy #_____ Group #_____

INITIAL HERE IF YOU CHOOSE TO NOT UTILIZE YOUR INSURANCE BENEFITS _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM/OBTAIN AUTHORIZATION FOR TREATMENT/AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MAURA LOFTUS, L.C.S.W. FOR PSYCHOTHERAPY SERVICES RENDERED:

Name_____ Signature _____

Date_____ /_____ /_____