



Sterling Behavioral Health Services, LTD

2007 Patient Information Update and Contact Agreement

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Patient

Last Name:		First name:	
Date of Birth:		Social Security Number:	
Marital Status:		Sex:	
Address:			
City:		State:	Zip Code:
Employer:			
Home Phone:		Fax:	
Work Phone:		Pager:	
Cell Phone:		Home e-mail:	
Other Phone:		Work e-mail:	

Emergency Contact

Name:	
Home Phone:	
Work: Phone:	
Cell Phone:	
Relationship:	
Notes:	

Parent / Guardian Information Required if the patient is under 18 years of age

Last Name:		
First name:		
Date of Birth:	Social Security Number:	
Custody Status: Legal:	Physical:	
Address:		
City:	State:	Zip:

Other Custodial Information:



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Primary Insurance Information (SBHS will need a copy of both sides of the insurance card)

Relationship to insured:	Employer:	
Group Number:		
Member ID Number:		
Effective Dates:	To:	From:

Insured's Information if not self

Relationship to insured:		
Last Name:	First name:	
Date of Birth:	Social Security Number:	
Marital Status:	Sex:	
Address:		
City:	State:	Zip Code:

Secondary Insurance Information

(If Applicable, SBHS will need a copy of both sides of the insurance card)

Sterling Behavioral Health Services, LTD does not bill secondary insurance except as required by law.

Insurance Company:		
Group Number:		
Member ID Number:		
Effective Dates:	To:	From:

Insured's Information if not self

Relationship to insured:	Employer:	
Last Name:	First name:	
Date of Birth:	Social Security Number:	
Marital Status:	Sex:	
Address:		
City:	State:	Zip Code:

I authorize Sterling Behavioral Health Services to contact me and leave messages for me using any of the above listed contact information except as individually excluded below.

Patient / Parent / Guardian: _____ Date: _____