CARITAS • 1711 W County Rd B, Suite 115S, Roseville MN 55113 - Tel/fax • 651-644-8235

Welcome! As a means of facilitating our bookkeeping system, we ask that you complete the following information. PLEASE PRINT ALL DATA

Client name: _____ Date of birth: _____
Last first middle

Address: _____
Street city state zip code

Gender: M F Home phone: _____ Work phone: _____

Cell phone: _____ At what number do you prefer to be reached? _____

Name of parent(s) or spouse: _____ Date of birth: _____

_____ Date of birth: _____

Name of siblings (for minors): _____ Date of birth: _____

or children _____ Date of birth: _____

_____ Date of birth: _____

Name of insured: _____ Social security #: _____

Relationship to patient: _____ Name of employer: _____

Insurance company: _____ Policy/ID #: _____

Group #: _____ Phone #: _____ Address: _____

_____

I understand that I am responsible for all fees not covered by insurance and that I will be charged for missed appointments and appointments not cancelled within 24 hours of the scheduled time.

Signature: _____ Date: _____

I would like this office to bill my insurance company, and this office may receive insurance payments for services provided. I also authorize the release of pertinent information regarding services provided for processing to Cathie G Welch LLC.

Signature: _____ Date: _____

Office use only:

Dx: _____ Intake date: _____ Referred by: _____