domestic abuse project
DAP

INSURANCE REGISTRATION FORM

Patient's Name (Last, First, MI): _____

Patient's Phone: _____ **Alternate Phone (** ☐ cell or ☐ work**):** _____

E-Mail Address: _____

Address: _____ **Apt. #:** _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Social Security Number:** _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Patient's Employer: _____

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Student ☐ Other: _____

Emergency Contact: _____ **Relationship to Patient:** _____

Address: _____ **Phone number:** _____

HEALTH INSURANCE INFORMATION (Insurer)

Primary Insurance: _____

Member ID: _____

Group ID: _____

Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

Secondary Insurance: _____

Member ID: _____

Group ID: _____

Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ **Relationship to Patient:** _____

Address: _____

Social Security Number: _____ **Date of Birth:** _____

Their Employer: _____ **Work Phone Number:** _____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above-named patient:

Name(s): Domestic Abuse Project Staff **Relationship to Patient:** Service Provider

_____

Participant Name / Caregiver Name (if applicable)

_____ _____

Participant / Caregiver Signature **Date**