

**Tanya Brown-Davis Counseling Service**  
**6401 Eldorado Pkwy, Suite 106, McKinney, TX 75070**

PATIENT INFORMATION FORM

Name \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

*I give my permission to be contacted at the phone numbers listed above.* \_\_\_\_\_  
*Initials*

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Circle One: Male /Female

Patient Employer/School \_\_\_\_\_ Employer/School Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Primary Insurance

Person Responsible for Account \_\_\_\_\_

Relationship to Client \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Insurance Company Name or Mental Health Network \* \_\_\_\_\_

Phone Number from Insurance Card \_\_\_\_\_

*(Note: Your card may have a separate phone number for mental health/substance abuse.)*

Account Number \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Employer \_\_\_\_\_

\* Please attach an enlarged copy of your insurance card (front and back) and an enlarged copy of your driver's license.

I certify that I and/or my dependents have insurance coverage with \_\_\_\_\_ and assign directly to Tanya Brown-Davis all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized use of my signature on all insurance submissions. Tanya Brown-Davis or her representatives may use my health care information for the purpose of obtaining payment and determining insurance benefits from the above named insurance company. The consent will end when treatment is completed.

Signature of Patient or Policyholder \_\_\_\_\_ Date \_\_\_\_\_

Please Print Name \_\_\_\_\_ Relationship to client \_\_\_\_\_