Recovery Pathways, LLC
Patient Demographics

Patient Information

Date_____Primary Care Doctor_____

Last Name_____First_____Middle_____

DOB_____Age_____Sex: ☐Male ☐Female ☐Transgender ☐Other_____
Race: ☐African Am. ☐Arab Am. ☐Asian/Pacific Islander ☐Hispanic ☐Multi-racial ☐Native Am. ☐White ☐Other_____
Relationship Status: ☐Single ☐Married ☐Partner ☐Divorced ☐Separated ☐Widowed ☐Other_____

Street Address _____

City/St/Zip_____County_____

SSN #_____Phone_____Cell_____

Employer_____Work Phone_____

Receive disability benefits (SSI) ☐Yes ☐No If yes, reason for benefits?_____
Are you a Veteran ☐Yes ☐ No If yes, do you receive VA benefits? ☐Yes ☐No
Do you receive Workers Compensation ☐Yes ☐ No If yes, date of injury _____

Insurance Information

Do you have insurance? ☐Yes ☐No
Insurance: ☐Medicaid ☐Medicare ☐BCBS ☐PPO/PPOM ☐Other_____

Insurance Company Name_____Phone_____

Subscriber's Name_____DOB_____SSN_____

Policy_____Group #_____Copay amt_____

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other_____

Secondary Insurance (if applicable)_____

Subscriber's Name_____DOB_____SSN_____

Insurance Co. Phone_____Policy_____Group #_____

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other_____

In Case of Emergency

Name of friend or relative not at same address_____

Relationship to Patient_____Phone _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Recovery Pathways, LLC. I understand that I am financially responsible for any balance. I also authorize Recovery Pathways, LLC or the insurance company to release any information required to process my claims.

_____ _____

Signature/Guardian Signature **Date**