

# Sterling Behavioral Health Services, LTD

## Patient Information Update and Contact Agreement

Initial Visit Date: \_\_\_\_\_

### 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:			
Cell Phone:		Home e-mail:	
Other Phone:		Work e-mail:	

### Emergency Contact

Name:	
Home Phone:	
Work Phone:	
Cell Phone:	
E-mail Address:	
Relationship:	

### 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:

**Patient Information Update and Contact Agreement**

**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 Secondary 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.

\_\_\_\_\_  
Patient / Parent / Guardian

\_\_\_\_\_  
Date

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