



Fairbanks Therapy Associates, Inc.

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Last name		First name		MI	
DOB			SS#		
Address			City		
State			Zip		
Home phone			Cell phone		
Email			Employer		
Insurance Co			Primary insured		
Insured DOB			Insured SS#		
Subscriber ID			Group #		
Plan name			Ins phone		
Ins address			Deductible		

Client Information

Date: _____