

ROSANNA O. ZAVARELLA, Ph.D.

24100 Chagrin Blvd., Suite 140  
Beachwood, OH 44122-5545  
tel: 216-321-3025

fax: 216-831-1269  
email: rzavarella11@gmail.com

8338 Tyler Blvd., 2<sup>nd</sup> Floor  
Mentor, OH 44060-4221  
tel: 440-205-5566

---

INSURANCE (page 5 of 5)

Patient Name: \_\_\_\_\_ Insurance Holder: \_\_\_\_\_  
(if different from patient)

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Clients relationship to insured:  Self  Spouse  Child  Other

---

SECONDARY INSURANCE (IF APPLICABLE)

Patient Name: \_\_\_\_\_ Insurance Holder: \_\_\_\_\_  
(if different from patient)

Insured ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Clients relationship to insured:  Self  Spouse  Child  Other

---

**PLEASE ATTACH AND SEND COPIES OF YOUR INSURANCE CARD(S) FRONT AND BACK  
WITH YOUR FILLED OUT AND SIGNED INTAKE FORMS. THANK YOU.**

NOTES:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_