NEW PATIENT INFORMATION FORM

PATIENT'S NAME: _____ MALE ☐ FEMALE ☐

PATIENT'S BIRTHDATE: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____CELL PHONE: _____ WORK PHONE: _____

NAME OF PRIMARY PHYSICIAN/PEDIATRICIAN: _____

SCHOOL: _____ GRADE: _____

IF PATIENT IS A MINOR (UNDER 18 YEARS OLD) PLEASE COMPLETE THE FOLLOWING SECTION:

FATHER'S NAME: _____ DATE OF BIRTH: _____
PLACE OF EMPLOYMENT: _____ PHONE: _____
☐MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

MOTHER'S NAME: _____ DATE OF BIRTH: _____
PLACE OF EMPLOYMENT: _____ PHONE: _____
☐MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

MEDICAL INSURANCE INFORMATION (INSURANCE CARD WILL BE NEEDED FOR THIS SECTION)

NAME OF INSURANCE CARRIER: _____

SUBSCRIBER'S NAME: _____DATE OF BIRTH: _____

INSURANCE ID #:_____CLASS OR GROUP: _____ RIDER: _____

ARE YOU COVERED BY OTHER MEDICAL INSURANCE? IF YES, PLEASE COMPLETE THE FOLLOWING:
NAME OF INSURANCE CARRIER: _____
SUBSRIBER'S NAME: _____DATE OF BIRTH: _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process any insurance claim(s). I also authorize payment of medical benefits for services described on above mentioned claim(s). I understand that I am ultimately responsible for payment of all services rendered, for payment of any reasonable attorney fees and all cost of suit if a legal suit is instituted to enforce collection of accounts past due, and recognize that I will be charged for appointments if canceled with less than 24 hours notice. If you participate in a managed care company and authorization is denied for treatment, it is understood that you will be billed directly for services provided. ***In order to utilize insurance, I understand that all co-pays must be paid at the time of visit.*** *I recognize that East Amherst Psychology Group is a Limited Liability Partnership. The Primary Care Physician may be consulted.*

SIGNED: _____ DATE: _____