

Please Print

PATIENT INFORMATION

Name: Last _____ First _____ M.I. _____

Address: _____

City: _____ State: _____ Zip _____

Telephone: Work (_____) _____ Ext _____

Home (_____) _____ Cell (_____) _____

Where may we leave messages? (Circle all that apply) Home Work Cell

Marital Status: _____ M ___ F Age _____

Soc Sec # _____ Date of Birth _____

PRIMARY INSURANCE

Insurance Company _____

Identification # _____ Group # _____

Insured Name: _____ Date of Birth: _____

Insured Address and Phone (if different) _____

(_____) _____ Insured Soc Sec # _____

Place of Employment: _____

SECONDARY INSURANCE (If applicable)

Insurance Company _____

Identification # _____ Group # _____

Insured Name: _____ Date of Birth: _____

Insured Address and Phone (if different) _____

(_____) _____ Insured Soc Sec # _____

Place of Employment: _____

Authorization to release information and pay benefits to the provider:

I hereby authorize Teresa A. Gorno-Reid, Psy.D. to release any information, acquired in the course of treatment, necessary to process insurance claims. I hereby authorize my insurance benefits to be paid directly to Teresa A. Gorno-Reid, Psy.D. I understand I am responsible for all charges not paid by my insurance.

Signature of Patient or Legal Guardian

Date