Patient History and Insurance Information

Last Name *Middle Initial* *First Name*

Street

City *State* *Zip*

Date of Birth Age Social Security Number

Home Phone *Cell Phone* *Work Phone*

Education

__High School __College __Other

Marital

__Single __Married__Partner__Separated__Divorced __Widowed

Employer *Employer Address* *Employer Phone*

Insurance

Insurance Co. *Policy number* *Group Number* *Insurance Phone*

Name of Person Insured *Date of Birth* *Address* *Phone*

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named insurance company and assign directly to Neuropsych all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information neccessary to secure payment of benefits I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

____Date_____________

Patient Signature

____ Date_____________

Emergency Contact

Name

Phone Number Relationship

Neuropsych (two locations) 847-367-1611