Patient Demographics/Insurance Form

Provider: Appointment date:

Patient Info

Name:

Gender:

Street Address:

City/State/Zip:

Date of Birth: Month: Day: Year:

Telephone #: Home: Work: Cell:

Email address:

Insurance Policy Subscriber Info

If same as patient check here: ☐ If not patient, relationship to patient:

Name:

Gender:

Street Address:

City/State/Zip:

Date of Birth: Month: Day: Year:

Telephone #: Home: Work: Cell:

Email address:

Guarantor Info

Is insurance subscriber the person responsible for payment of the bill?: ☐ yes ☐ no

If no, enter name/address Name:

Street Address:

City/State/Zip:

Insurance Plan Info:

Insurance Company Name:

Insurance Company Phone #:

Employer name or group # of plan:

Insurance Policy ID # (include both alpha and numeric characters)

Psych / Neuropsych Testing Intake Information

Provider:

Appointment date:

Patient Name:

Referring MD or other referring provider:

Doctor Name:

Doctor Street Address:

City, State, Zip:

Doctor Phone #:

Doctor NPI #:

Testing to be performed/Services requested:

Mental Health:
90791: (# hours):
96101 (# hours):
96102 (# hours):
96103 (# hours):

90832 (# hours):
90834 (# hours):
90837 (# hours):
90846-90847 (# hours):

Other codes (# hours):

Diagnosis/diagnoses being tested:

Medical/Neuropsychology:
96116 (# hours):
96118 (# hours):
96119 (# hours):
96120 (# hours):

Other codes (# hours):
Diagnosis/diagnoses being tested: