New Patient Information

Please fill out the following information to the best of your ability. Do not leave any sections blank. If you have any questions, please ask for assistance.

Identifying Information:

Patient Full Name: _____M/F Date of Birth: _____
Address:_____ _____City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Employer Name: _____ Employer Address: _____
Social Security Number: _____
Spouse Name: _____M/F Date of Birth: _____
Spouse Employer: _____ Spouse Social Security Number: _____
Mailing Address (if different from above): _____

Parent or Guardian: (Skip to next section if patient is not a minor)

Mother's full name: _____ Date of Birth: _____
Address:_____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Employer Name: _____ Employer Address: _____
Social Security Number: _____
Father's full name: _____ Date of Birth: _____
Address:_____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Employer Name: _____ Employer Address: _____
Social Security Number: _____

Other Information:

Emergency Contact Person: _____ Home Phone: _____
Relationship to patient: _____
How did you hear about us?:_____
Reason for Referral: _____

Insurance Information: Please provide a copy of your insurance card(s) in addition.

Primary Insurance: _____
ID# _____
Group # _____
Name of Subscriber: _____
Address of Subscriber: _____
Subscriber DOB: _____
Subscriber SS# _____

Secondary Insurance: _____
ID# _____
Group # _____
Name of Subscriber: _____
Address of Subscriber: _____
Subscriber DOB: _____
Subscriber SS # _____

Primary Care Physician
Physician's Name: _____ Phone: _____
Physician's Address: _____
I DO/DO NOT (Circle one) authorize the mutual exchange of information between Behavioral Medicine Associates, Inc. and my/my child's primary care provider. This authorization does not expire unless noted as follows: _____. Signature: _____

School If not applicable, skip to next section.
School Name: _____ Grade: _____ Teacher: _____
Address: _____ Phone: _____
I DO/DO NOT (Circle one) authorize the mutual exchange of information between Behavioral Medicine Associates, Inc. and my child's school. This authorization does not expire unless noted as follows: _____. Signature: _____

Other: (i.e. Referral Source, lawyer, other physician, etc.)
I DO/DO NOT (Circle one) authorize the mutual exchange of information between Behavioral Medicine Associates, Inc. and _____. This authorization does not expire unless noted as follows: _____. Signature: _____

I hereby assign, transfer, and set over to Behavioral Medicine Associates, Inc. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patients name (Print): _____ Todays Date: _____
Signature of patient/parent (if under 18): _____

I received a copy of *The Notice of Privacy for Patients.* Initial _____

I received a copy of the *Patient Grievance Policy.* Initial _____

I DO/DO NOT (Circle one) authorize Behavioral Medicine Associates, Incorporated to photograph me/my child for the purpose of identification in the patient chart and/or psychological reports. I understand that I can revoke this authorization at any time with no penalty.
Signature of patient/parent (if under 18): _____