Patient Registration/Insurance (Please Print)

Name____ Maiden Name_______________

Last First Middle Initial

Birthdate______________ Phone______________________ May I call you at home? Yes No

Address____ Marital Status: S M W D

City___________________________ State______________________ Zip Code _____________

Your Occupation _____________________________ Business Phone _______________________

Email address_______________________________ Cell Phone____________________________

Employed by & Address ____

Who may I thank for referring you? ____

Primary Insurance ***Secondary Insurance***

Name & Address of Insurance Company

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Name of Policy Holder ____

Policy, Group & All
Other Ins. Numbers ____

Your Social Security # _________________________ Spouse Security # _______________________

In case of an emergency who may we contact (other than a spouse) ___________________________

Assignment and Release

Authorization for Release of Information and Assignment of Benefits

I hereby authorize Rebecca Dwyer-Elias, LCSW, LISW release t my insurance company any information necessary to process my medical services rendered to my dependants or myself. I understand that I am responsible for any amount not covered by insurance.

______________________________ ________________ ___________________

Responsible Party Signature Relationship Date