NEW PATIENT INFORMATION SHEET

Patient Name: Last_____First _____

Address:_____ City:_____

State:_____ Zip Code:_____ Home Phone:_____

Cell Phone:_____ Work Phone:_____

E-mail:_____

Marital Status: Married Single Birth Date:_____ Age:_____

Social Security #: _____ Referral Source:_____

Where do you prefer messages be left: _____

Insured Name, Address and phone# (if different from patient)

_____

Employer of Insured :_____

Insured Date of Birth:_____Social Security #:_____

Primary Insurance:_____I.D.#_____

Group #_____Customer Service telephone#_____

Billing address:_____

I hereby acknowledge that I received an explanation of Dr. Tompkins' Psy.D. & Associates business practices. I hereby authorize my insurance benefits to be paid directly to Denise Tompkins, Psy.D. & Associates and I hearby authorize the release any information acquired in the course of treatment that is necessary to process insurance claims. I understand that I am responsible for all charges not paid by my insurance. I also agree to pay all collection agency fees should I default in payment.

_____ _____

Signature of Patient or Legal Guardian Date

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