THE NEUROPSYCHOLOGY CONSULTANTS

Neuropsychological Evaluation, Neurobehavioral Management, Forensic Neuropsychology, Clinical Psychology

PATIENT INFORMATION SHEET

Date____________________ Referred By____________________ Physician & Phone____________________

Last Name_________________________ First Name_________________________ Middle_______________

Address____
Street City State Zip

Home Home Phone #_______________________________ Work Phone____________________________________

Date of Birth_______________ Age______________ Sex___________ Social Security # _____-_____-______

Driver's License Number & State_________________________ Email address__________________________

Emergency Contact Person_____________________________________ Phone #________________________

Highest Education Completed____

Student Status (circle one): Not a student Part time student Full time student

Marital Status (circle one): Married Single Divorced Widowed Legally Separated

Employment Status (circle one): Full time Part time Unemployed Self Employed Retired Military

If Employed, Employer Name & Address____

HOUSEHOLD MAKEUP

Name	Age	Relationship

INSURANCE INFORMATION

Patient Relationship to Insured (circle one): Self Spouse Child Other____________________________

Primary Insurance:	ID # Group #
Billing Address:	City, State, Zip:
Primary Insured's Name:	Primary Insured's Employer:
Primary Insured's SSN# _______-_______-_______	Primary Insured's Date of Birth:

Secondary Insurance:	ID # Group #
Billing Address:	City, State, Zip:
Secondary Insured's Name:	Secondary Insured's Employer:
Secondary Insured's SSN# _______-_______-______	Secondary Insured's Date of Birth:

Insurance Authorization & Release

1. I authorize use of this form on all of my insurance submissions.
2. I authorize release of information to my insurance company(s).
3. I authorize payment to my service provider
4. I understand that I am responsible for any deductible amount, co-pay, co-insurance amount or any other balance not paid by my insurance, and that payment is due when services are rendered.
5. I attest that the above insurance information is accurate to the best of my knowledge.

Signature____ Date_______________________________

Guardian's Signature (if applicable)__________________________________ Date___________________