FALLS NEUROPSYCHOLOGY AND PSYCHOTHERAPY ASSOCIATES, PLLC
REGISTRATION FORM

(Please Print)

Today's date:	Clinician:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Home Telephone:	Work Telephone:	Mobile Telephone:

Street Address:	Social Security Number:

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:

Chose FNPA because/Referred to FNPA by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to your clinician.) Insurance Company:

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Falls Neuropsychology and Psychotherapy Associates, PLLC. I understand that I am financially responsible for any balance. I also authorize Falls Neuropsychology and Psychotherapy Associates, PLLC and my insurance company to release any information required to process my claims. In case of emergency, I authorize Falls Neuropsychology and Psychotherapy Associates to contact the above named person or designated other on my behalf.

Patient/Guardian signature *Date*