

# FALLS NEUROPSYCHOLOGY AND PSYCHOTHERAPY ASSOCIATES, PLLC REGISTRATION FORM

(Please Print)

Today's date:				Clinician:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY				
Name of local friend or relative:		Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
<p>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.</p>				
<hr style="border: none; border-top: 1px solid black;"/> <i>Patient/Guardian signature</i>			<hr style="border: none; border-top: 1px solid black;"/> <i>Date</i>	