

Registration Form

Elizabeth Shryer Boyle Psychological Services

Date _____

DX Code _____

Patient Information

Patient Name (Print) _____ Date of Birth _____
Last Name First Name Initial

Street Address _____ Home Phone _____

City _____ State _____ ZIP _____ Work Phone _____

Soc. Sec. # _____ Emergency Contact _____ Emerg Phone _____

Sex: Female Male Age _____ Marital Status: Single Married Partnered Divorced Separated Widowed Other

Employer _____ Occupation _____

E-mail Address: _____ Referred by: _____

Primary Insurance

Primary Insurance Company _____ Phone _____

Ins Claims Address _____ City _____ State _____ Zip _____

Policy/ID # _____ Group/Plan # _____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name _____ Relationship _____
Last name First Name Initial

Address _____ City _____ State _____ Zip _____ Date of Birth _____

Soc. Sec# _____ Employer _____

Secondary Insurance

Secondary Insurance Company _____ Phone _____

Ins Claims Address _____ City _____ State _____ Zip _____

Policy/ID # _____ Group/Plan # _____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name _____ Relationship _____
Last name First Name Initial

Address _____ City _____ State _____ Zip _____ Date of Birth _____

Soc. Sec# _____ Employer _____

Responsible Party (Where should the patient's portion of the bill be sent, if not to the patient?)

Name _____ Relationship _____

Address _____ Phone _____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship To Patient

Date