Gary Elkins, Ph.D., ABPP
Patient Information

Client's Name: _____ Date of Birth: _____

Client's Address: _____ SSN:_____

City, State, Zip: _____Home Phone: _____

Work Phone: _____ Cell Phone: _____

Marital Status *(Circle one)*: Single Married Divorced Separated

Sex (*Circle one)*: Male Female

Insurance Information: (Primary Insurance)

Name of Insurance: _____ Insurance Phone #: _____

Relationship to Insured *(Circle one)*: Self Spouse Child

Insured's Employer Name: _____Group #: _____

Insured's Employer Address: _____

Do you have other insurance? (Secondary Insurance) Yes No

(i.e. Medicaid, USAA, Health Plan, etc.)

Name of Insurance_____ Insurance Phone #: _____

If TriCare, please circle those that apply: Prime Standard Active Retired

Insured/Sponsor's Name: _____ Insured's Date of Birth: _____

Insured/Sponsor's ID #: _____ Relationship to Insured: Self Spouse Child

Insured's Employer Name: _____Group #: _____

Insured's Employer Address: _____

SIGNATURE ON FILE

I authorize release of any medical or other information necessary to process claims to my insurance companies. I also request payment of government benefits either to myself or to the party who accepts assignment on the claims. I authorize payment of medical benefits to the physician or supplier for services described on insurance claims. I understand that verification of insurance benefits is not a guarantee of payment and that any unpaid balance is my responsibility.

_____ _____

Signature Date

OFFICE USE ONLY

Dx: _____Fee: _____ Intake Date: _____Provider: _____