Patient Registration – **Child**

Kelly M. Baskind, Ph.D.

Patient Name:_________________________________Nickname:_______________

Date of Birth ____/____/_______ Male ___ Female ___

Address:_______________________________City:_____________Zip Code:_______

Phone: Cell __________________ Home:___________________

Mother:______________________________Address:__________________________
Date of Birth: ___/____/____ Employer: _____________________________________

Father:_______________________________Address__________________________
Date of Birth: ___/____/____ Employer: _____________________________________

Primary Care Physician:_______________City_________Phone:________________

Food/ Drug Allergies:

____

INSURANCE INFORMATION:

Primary Insurance: Insurance Company: ___________________________
Employer:________________________

Subscriber/PolicyHolder:________________________ Date of Birth:____/____/____

Contract/Policy#:________________________Group/ Plan #: ____________

Secondary Insurance: Insurance Company: ___________________________
Employer:_______________________

Subscriber/PolicyHolder:_______________________ Date of Birth:____/____/____

Contract/Policy#:____________________________ Group/Plan#:_____________

Insurance Authorization: I hereby authorize Dr. Baskind to furnish information to my insurance carriers concerning my diagnosis and treatment, and I hereby assign to the psychologist all payments for services rendered to myself or dependents. I understand that I am responsible for any amount not covered by insurance.

HIPAA: I have read the HIPAA office policies. They are posted on our website and in our office ________
initial

Date: __________ Signature: _____________________________

Witness: _____________________________