Patient Registration – Child

T. Michael Knack, Ph.D.

Patient Name: ___________________________________ Nickname: ______________________

Date of Birth ____/____/_______ Male ___ Female ___ Marital Status: S M D W

Address: _________________________________ City: ______________Zip Code: ____________

Telephone: Cell# (__)____-______ Work/Home # :(___)_____-______ Soc Sec #: ____________

Mother: ________________________________ Address: ________________________________

Soc Sec #: _________________ Date of Birth: ___/____/____ Employer: __________________

Father: _________________________________ Address: _______________________________

Soc Sec #: _________________ Date of Birth: ___/____/____ Employer: __________________

Primary Care Physician: ______________________ City: _________________

PCP Phone #____________________ Fax# _______________________

Food/ Drug Allergies: ____

INSURANCE INFORMATION:

Primary Insurance:

Name of Insurance Company: ____________________________ Employer: ________________

Subscriber/ Policy Holder: _______________________________ Date of Birth: ____/____/____

Contract/Policy #: _____________________________________Social Security #: ____________

Group #: ______________________ Plan #: _____________

Secondary Insurance:

Name of Insurance Company: ____________________________ Employer: ________________

Subscriber/ Policy Holder: _______________________________ Date of Birth: ____/____/____

Contract/Policy #: _____________________________________Social Security #: ____________

Group #: ______________________ Plan #: _____________

Insurance Authorization:

I hereby authorize T. Michael Knack, Ph.D. 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 dependents or myself. 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