Sean Flynn, Ph.D., P.C.

Psychologist
5920 E. Pima Road, Suite #140
Tucson, AZ 85712
(520) 733-2524

Patient Registration Information

Date _____/_____/_____

PLEASE PROVIDE AS LEGIBLE AS POSSIBLE THE FOLLOWING INFORMATION

Patient Name	**Phone**	**Date of Birth** _____/_____/_____	**Age**
Address	**Gender**	**Social Security No.** - -	
City **State**	**Zip Code**	**Marital Status** S M W D RM SP Co	**Partner's Name**
Employer	**Occupation**	**Work Phone**	
Referral Source	**Patient's Medical Doctor**		

RESPONSIBLE PARTY/PRIMARY CARD HOLDER

Name	**Social Security No.**	**Relationship**	**Home Phone**
Address	**City** **State**	**Zip Code**	**Date of Birth** ____/____/____
Employer	**Address**	**Work Phone**	

NOTICE IN CASE OF EMERGENCY

Name	**Relationship**	**Home Phone**	**Work Phone**
Address	**City**	**State**	**Zip**

INSURANCE INFORMATION

Primary Behavior Health Insurance Carrier	**Phone No.**	**Identification No.**
Address	**City** **State**	**Primary Group No.**
Secondary Behavioral Health Insurance Carrier	**Phone No.**	**Secondary Group No.**

Our office provides the service of "reminder calls." To protect your privacy, please indicate how you would prefer this to be done. (Please choose one of the following)

- □ **Leave message at your home number**
- □ **Call you at your work or alternate phone number: _____**
- □ **You prefer that staff does not confirm your appointment.**

Please read and sign:

I authorize the release of any of my medical, psychiatric or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of medical benefit to the physician or supplier for services rendered. I fully understand that if my insurance denies payment for any service defined as a non-covered service, I will be responsible for any amount due.

_____ _____

Signature of Patient/Parent or Guardian **Date**