PATIENT DATA SHEET

Peter C. Zubritzky, Licensed Psychologist

The following information is needed for our records. Please PRINT and Sign this form upon completion.

Name ______________________ Date of Birth ______________________ Age ________

Social Security # ______________________ Email ______________________

Address ____

Home Phone # ______________________ Cell Phone # ______________________

Emergency Contact ______________________ Phone # ______________________

Marital Status: Single ___ Married ___ Other___

Are You Employed: Yes ___ No ___ If so, where ______________________

___ Have you applied or are you applying for any type of disability, including Social Security & Workers' Compensation? If yes, please ask receptionist for a copy of the policy and cost for completing necessary documentation.

Name of Primary Care or Referring Physician ______________________

Are you currently taking any medications? Yes ___ No ___ If so, please list: ______________________

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Are you currently under a doctor's care? Yes ___ No ___ If so, please describe illness for which you are being treated:

____

Primary Insurance: ______________________ ID # ______________________ Group # ______________________

Subscriber Name: ______________________ Date of Birth: ______________________

Relationship to Patient: Self ___ Spouse ___ Other ___

Secondary Insurance: ______________________ ID # ______________________ Group # ______________________

Subscriber Name ______________________ Date of Birth ______________________

Relationship to Patient: Self ___ Spouse ___ Other ___

I affirm that the information I have provided is truthful and to the best of my knowledge. I hereby authorize the office of PETER C. ZUBRITZKY, Ph.D., to release any medical information in the course of examination/treatment and permit payment directly to my insurance company for any benefits for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage and that I am responsible for all charges not paid by my insurance, including any deductible amount, co-insurance or any amount of payment, etc. Payment is to be made at the beginning of each appointment and a receipt will be provided to me, the patient, for non-participating carriers or if I choose to pay and file my own insurance forms. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF $50.00 FOR APPOINTMENTS SCHEDULED AND NOT CANCELLED WITHIN 24 HOURS NOTICE.

Signature: ______________________ Date: ______________________