

TUCKER PSYCHIATRIC

OFFICE USE ONLY		
Date	Account #	Doctor

PATIENT INFORMATION		
First Name (Legal)	Middle Initial	Last
Address: Street		
City	State	Zip
Phone Number	Cell Phone Number	
Age	DOB	Sex
Phone # In Case of Emergency		
Social Security Number		

BILLING INFORMATION		
Responsible Party/Custodial Parent (If same as above, skip to insurance information)		
Address - Street		
City	State	Zip
Phone Number		

PRIMARY INSURANCE	
Ins. Company Name	
Effective Date	Expiration Date
Policy Holder's Name	Relationship to Patient
Policy Number	Group Number
Policy Holder's SS Number	Policy Holder's Date of Birth
Policy Holder's Employer Name	
Phone Number	

I Consent To Receive Reminder Calls Prior To Appointments. Yes No

SECONDARY INSURANCE (Medicare supplement or secondary insurance)	
Ins. Company Name	
Policy Holder's Name	Relationship to Patient
Policy Number	Group Number
Policy Holder's SS Number	Policy Holder's Date of Birth
Policy Holder's Employer Name	
Phone Number	

MOTHER'S INFORMATION		
Name	DOB	MAR ST
Social Security Number		
Address (if different than patient)		
City/State/Zip		
Home Phone #		
Employer	Work Phone #	
Cell Phone #		

FATHER'S INFORMATION		
Name	DOB	MAR ST
Social Security Number		
Address (if different than patient)		
City/State/Zip		
Home Phone #		
Employer	Work Phone #	
Cell Phone #		

EMERGENCY CONTACT
Name
Relationship to Patient
Address
City/State/Zip
Phone #
Cell Phone #

OTHER INFORMATION	
If Medicare: Are you employed? ___ Yes ___ No Are you covered by an employer health insurance? ___ Yes ___ No	
REFERRED BY: <input type="checkbox"/> (1) FAMILY DOCTOR <input type="checkbox"/> PEDIATRICIAN <input type="checkbox"/> (2) RELATIVE/FRIEND <input type="checkbox"/> INTERNET <input type="checkbox"/> INSURANCE CO. <input type="checkbox"/> (5) THERAPIST	
NAME OF REFERRING DOCTOR _____	