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General and Adult Psychiatry
Child and Adolescent Psychiatry
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Completion of this form in its **ENTIRETY** is required at the time of the visit.

PATIENT INFORMATION

Last name: ____

First name: ____

Middle name: ____

Address: ____

City: ____________________ State: ______________ Zip code: __________________

Phone number: ____

Social security number: ____

Date of birth: ____

Age: ____

Male/Female (circle one)

PATIENT'S FATHERS INFORMATION

Last name: ____

First name: ____

Middle name: ____

Address: ____

City: ________________________ State: ____________ Zip code: ______________

Previous address (if less than 3 years): ________________________________

Home phone number: ____

Work phone number: ____

Cell phone number: ____

Social security number: ____

Date of birth: ____

Marital status: ____

Occupation: ____

Employer's name: ____

Employer's address: ____

City: ______________________ State: ____________ Zip code: ________________

Employer's phone number: ____

PATIENT'S MOTHERS INFORMATION

Last name: ____

First name: ____

Middle name: ____

Address: ____

City: ________________________ State: ______________ Zip code: ______________

Previous address (if less than 3 years): ________________________________

Home phone number: ____

Work phone number: ____

Cell phone number: ____

Social security number: ____

Date of birth: ____
Marital status: ____
Occupation: ____
Employer's name: ____
Employer's address: ____
City: ___________________________State: ____________________ Zip code: ___________________
Employer's phone number: ____

PERSON ASSUMING FINANCIAL RESPONSIBILITY FOR THE PATIENT

(person signing this form)

Last name: ____
First name: ____
Middle name: ____
Address: ____
City: ________________________________ State: ____________________ Zip code: _________________
Previous address (if less than 3 years): ____
Social security number: ____
Date of birth: ____
Marital status: ____
Home phone number: ____
Work phone number: ____
Cell phone number: ____
Occupation: ____
Employer's name: ____
Employer's address: ____
City: ________________________________ State: ________________ Zip code: _____________________
Employer's phone number: ____
Relationship to patient: ____

INSURANCE INFORMATION

Name and address of primary insurance company_______________________________________
____
Insurance company phone number: ____
Policyholder's first and last name: ____
Policyholder's date of birth: ____
Policyholder's employer: ____
Policy number: ____
Group number: ____
Policyholder's relationship to patient: ____

LOCAL FRIEND OR RELATIVE OTHER THAN LISTED ABOVE

Name: ____
Address: ____
City: ________________________________ State: ___________________ Zip code: __________________
Phone number: ____
Relationship to patient: ____

REFERRED BY

Patient's primary care physician: ____
Referred to me by: ____
Reason for referral: ____

Previous therapy? ____
If so with whom? ____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS.
I hereby authorize Dale B. Mortimer, M.D., P.C. to bill my child's insurance company and accept payment from that company on my child's behalf for all services. I hereby authorize Dale B. Mortimer, M.D., P.C. to provide my child's insurance company with any/all information requested concerning my child's present claims relating to his/her care. I acknowledge that I am responsible for all charges not covered by my child's insurance.

Responsible party's signature: ____ Date: _______________

AUTHORIZATION TO PROVIDE REASONABLE AND PROPER MEDICATION CARE

Parent or legal guardian signature: ____ Date: ______________