PSY
PSYCHOLOGICAL
SERVICES, P.C.

JEROLD M. GRODIN, Ph.D., DIRECTOR

SARATOGA OFFICE: 526 MAPLE AVENUE, SARATOGA SPRINGS, NY 12866 TEL 518-587-4161 FAX 518 587-5134
CLIFTON PARK OFFICE: 632 PLANK ROAD, CLIFTON PARK, NY 12065

NEW PATIENT REGISTRATION

PATIENT'S NAME: _____ **DOB:** _____ **AGE:** _____

ADDRESS: _____ **CITY:** _____ **STATE/ZIP** _____

HOME PHONE: _____ **WORK #:** _____ **CELL #:** _____

SS #: _____ **SEX:** ___M ___F **MARITAL STATUS:** ___S ___M ___D ___W

REFERRED BY: _____ **PRIMARY PHYSICIAN** _____

OCCUPATION; _____ **EMPLOYED BY:** _____

SPOUSE'S NAME: _____ **SPOUSE'S SS#:** _____

IF PATIENT IS A MINOR, PLEASE FILL IN THE FOLLOWING AND ABOVE:

LEGAL GUARDIAN NAME: _____ **DOB:** _____

RELATIONSHIP TO PATIENT: _____ **GUARDIAN SS#:** _____

ADDRESS: _____ **CITY:** _____ **STATE/ZIP:** _____

HOME PHONE #: _____ **CELL PHONE #:** _____

NAME OF *PRIMARY* INSURANCE PLAN: _____ **INSURED'S DOB:** _____

INSURED'S NAME: _____ **INSURED EMPLOYED BY:** _____

RELATIONSHIP TO PATIENT: ___SELF ___SPOUSE ___PARENT ___OTHER

SUBSCRIBER ID#: _____ **GROUP #:** _____ **COPAY: $** _____

NAME OF *SECONDARY* INSURANCE PLAN: _____ **INSURED'S DOB:** _____

INSURED'S NAME: _____ **INSURED EMPLOYED BY:** _____

RELATIONSHIP TO PATIENT: ___SELF ___SPOUSE ___PARENT ___OTHER

SUBSCRIBER ID#: _____ **GROUP #:** _____ **COPAY: $** _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS IS MADE EITHER TO ME, OR ON MY BEHALF, TO PSYCHOLOGICAL SERVICES, P.C. FOR SERVICES FURNISHED ME BY SUPPLIER.

I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE NOT PAID BY MY INSURANCE.

SIGNED _____ ***DATE:*** _____
(PATIENT'S SIGNATURE OR GUARDIAN IF PATIENT IS UNDER 21)

LIST ALL NAMES OF FAMILY, FRIENDS OR OTHERS THAT WE MAY DISCUSS YOUR PHI WITH (INCLUDE THOSE WHO MAY CALL ON YOUR BILL):

_____ _____

_____ _____