Patient Registration – Adult

Kelly M. Baskind, Ph.D.

Patient Name: _____ Nickname: _____
Date of Birth ____/____/_____ Male ___ Female ___ Marital Status: S M D W
Address: _____ City: _____Zip Code: _____
Telephone: Home #: (__) ___-_____ Work # :(___) ____-_____ Soc Sec #: _____
Patient's Employer: _____ Employer Phone: (___) ___-____
Employer Address: _____ City: _____State: _____ Zip: _____
Primary Care Physician: _____ City: _____
Food/ Drug Allergies: _____
Name and Address of Nearest Relative/Friend (NOT LIVING WITH YOU) Name: _____
Address: _____ City: _____ State: ____ Zip: _____ Phone: _____

INSURANCE INFORMATION:

Primary Insurance:
Name of Insurance Company: _____ Employer: _____
Subscriber/ Policy Holder: _____ Date of Birth: ____/____/____
Contract/Policy #: _____Social Security #: _____
Group #: _____ Plan #: _____

Secondary Insurance:
Name of Insurance Company: _____ Employer: _____
Subscriber/ Policy Holder: _____ Date of Birth: ____/____/____
Contract/Policy #: _____Social Security #: _____
Group #: _____ Plan #: _____

Insurance Authorization:

I hereby authorize Dr. Baskind to furnish information to my insurance carriers concerning my diagnosis and treatment, and I hereby assign to the psychologist all payments for services rendered to myself or dependents. I understand that I am responsible for any amount not covered by insurance.

_____ _____
Date Signature

_____
Witness