

# Tim Dallacqua LCSW, PLLC REGISTRATION FORM

(Please Print)

Today's date:			PCP:			
<b>PATIENT INFORMATION</b>						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age: 
Street address:			Social Security no.:		Home phone no.: (    )	
P.O. box:		City:		State:	ZIP Code:	
Occupation:		Employer:			Employer phone no.: (    )	
Email Address :						

<b>INSURANCE INFORMATION</b>					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: (    )
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:		Employer:	Employer address:		Employer phone no.: (    )
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance		<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]
<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> Other	
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

<b>IN CASE OF EMERGENCY</b>			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: (    )
			Work phone no.: (    )
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.</p>			
<hr style="border: 0; border-top: 1px solid black;"/> <i>Patient/Guardian signature</i>			<hr style="border: 0; border-top: 1px solid black;"/> <i>Date</i>