Authorization:
Copayment:

Timothy D. Berry, Ph.D.

Patient Registration Form

For Office Use Only
Fee: _____
Dx: _____
_____

Name(Last, first, middle initial)		Social Security number	Sex (M/F)
Street Address/Mailing address			Birth Date
City, State		Zip	
Marital status (S/M/D/CO-HAB)	Spouse/partner's name	Home Phone ( )	Mobil Phone ( )
Email Address (for our purpose only)	Would You Like to be Notified of Special Events by email? Y/N	Would You Like to Receive Our E-Newsletter? Y/N	
Employers Name	Occupation	Work Phone (If Ok to Call) ( )	
Emergency Contact's Name and Address		Emergency Phone ( )	
Referral Source	Primary Care Physician & Phone		
List Medications and Allergies (use back of sheet if needed)			

Did You Get Insurance Authorization Prior to Your First Visit? ____ Yes ___ No

Primary Insurance Company Name	ID number	Group number
Address	Effective Date	Phone Number ( )
Policy Holder's name	Relationship to Patient	Holder's SS #
Secondary Insurance Company Name	ID number	Group number
Address	Effective Date	Phone Number ( )
Policy Holder's name	Relationship to Patient	Holder's SS #

I authorize communication with my primary care physician _____ **Yes** _____ **No**

I authorize payment of medical benefits to Dr. Berry and I understand that I am responsible for any amounts **NOT** covered by Insurance benefits.

Signature _____ Date _____