**DENNIS R. VERVILLE, PSYD**

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| **(Please Print)** | | | | | | | | | |
| **PATIENT REGISTRATION SHEET** | | | | | | | | | |
| **Today's Date:** | | | | |  | | | | |
| **PATIENT INFORMATION** | | | | | | | | | |
| **Last Name: First: Middle:** | | | | | | **Mr.**  **Mrs.**  **Miss**  **Ms.** | | | **Marital Status (circle one)**    **Single/Mar/Div/Sep/Wid** |
| **Street Address:** | | | **City:** | | | **State:** | | | **Zip Code:** |
| **Home Phone: OK to contact? Y or N**  **( )** | | | **Email address:** | | | | | | **Birth date:**  **/ /** |
| **Cell Phone: OK to contact? Y or N**  **( )** | | | **Social Security no:** | | | | | | **Sex (circle one)**  **M F** |
| **Employer:** | | | **Occupation:** | | | | | | **Work Phone:**  **( )** |
| **Street Address:** | | | | **City:** | | | **State:** | | **Zip code:** |
| **Referring Doctor (if required by Insurance)** | | | |  | | | | | |
| **Notify Primary Care Physician?**  **Yes or No** | | | | **Name of primary Care Physician:** | | | | | **Phone:** |
| **IN CASE OF EMERGENCY** | | | | | | | | | |
| **Emergency Contact Name:** | **Home Phone:**  **( )** | | | | | | **Cell Phone:**  **( )** | | |
| **INSURANCE INFORMATION** | | | | | | | | | |
| **Insured's Last Name: First: Middle:** | | | | | **Marital Status (circle one)**    **Single/Mar/Div/Sep/Wid** | | | **Relationship to Insured:**  **Self**  **Spouse**  **Dependent** | |
| **Home Phone (if different)** | **Cell Phone (if different)** | | | | | | | **Birthdate:**  **/ /** | |
| **Primary Insurance Company:** | **Insurance Billing Address:** | | | | | | | **Insurance Phone:** | |
| **Policy Number:** | | | | | | | | **Group Number:** | |
| **SECONDARY INSURANCE INFORMATION (if applicable)** | | | | | | | | | |
| **Insurance Company:** | | **Insurance Billing Address:** | | | | | | **Insurance Phone:** | |
| **Policy Number:** | | | | | | | | **Group Number:** | |
| **The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance due. I authorize Dennis R. Verville, Psy.D., those acting on the practice's behalf, and my insurance company to release any information required to process my claims.**  **I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient/Guardian signature Date** | | | | | | | | | |

**\**PLEASE NOTE: 24 HOUR CANCELLATION POLICY* - Please be advised that 24 hours notice is required for cancellations. Otherwise, your account will be charged the session amount. Thank you for your cooperation. revised 4/20/18**