**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**