(Office use only: DX CODE _____)

Timothy S Cahn, PhD

PATIENT INFORMATION

Patient Name: _____ Sex: M [ ] F [ ]

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home: (_____)_____ May I call this number? Y N Leave a message? Y N

Cell: :(_____)_____ May I call this number? Y N Leave a message? Y N

Email: _____ May we email? Y N

SS#: _____ Date of Birth: _____Employer: _____

Spouse/Partner: _____ Phone#: _____ May we release information? Y N

Emergency Contact: _____ Phone#: _____ May we release information? Y N

PERSON RESPONSIBLE FOR PAYMENT (IF NOT PT) NAME: _____

Billing Address with City/Zip Code: _____

Phone # Hm: _____ Wrk: _____ Relationship to patient: _____

Employer: _____SS#:_____

Signature: _____ Date: _____

INSURANCE INFORMATION (Complete in full and provide a photocopy of your card)

Is condition the result of an accident? Yes [ ] NO [ ] If yes, Date of Injury: _____

Auto Accident [ ] Work Related injury [ ] Other [ ] _____CLAIM # _____

Name of Case Manager: _____ Telephone number:_____

Primary Insurance Company: _____ Phone #: _____

Subscriber Name: _____ Employer: _____

Relationship to patient: _____Male [ ] Female [ ] Subscriber date of birth: _____

Effective Date: _____ Group #: _____ ID #: _____

Secondary Insurance Company: _____ Phone #: _____

Subscriber Name: _____ Employer: _____

Relationship to patient: _____Male [ ] Female [ ] Subscriber date of birth: _____

Effective Date: _____ Group #: _____ ID #: _____

REFERRAL SOURCE

Name of referring physician or other source: _____

Name of primary care physician: _____

RELEASE/CONSENT

I hereby give my consent for psychiatric and/or medical consultation and treatment. I understand that Dr. Cahn is an independent practitioner and no other clinician is involved in the consultation and/or my treatment. I agree to be financially responsible for all charges for treatment and/or cancelled appointments as outlined in Dr. Cahn's financial policy. I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits directly to Dr. Cahn.

Signature of Patient or Legal Guardian _____Date: _____