Dale B. Mortimer, M.D., P.C.
Physician
General and Adult Psychiatry
Child and Adolescent Psychiatry
Diplomate, American Board of Psychiatry and Neurology

Completion of this form in its **ENTIRETY** is required at the time of the visit.

PATIENT INFORMATION

Last name: _____
First name: _____
Middle name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone number: _____
Cell phone number: _____
Work phone number: _____
Social security number: _____
Date of birth: _____
Age: _____
Male/Female (circle one)
Marital Status: _____
Occupation: _____
Name and address of employer: _____
_____

PATIENT'S SPOUSE INFORMATION

Last name: _____
First name: _____
Middle name: _____
Home phone number: _____
Work phone number: _____
Cell phone number: _____
Social security number: _____
Date of birth: _____
Occupation _____
Name and address of employer _____
_____

PERSON ASSUMING FINANCIAL RESPONSIBILITY FOR THE PATIENT

(person signing this form)

Last name: _____
First name: _____
Middle name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Previous address (if less than 3 years): _____
Social security number: _____
Date of birth: _____
Home phone number: _____
Work phone number: _____
Cell phone number: _____

Occupation: _____
Employer's name: _____
Employer's address: _____
City: _____ State: _____ Zip code: _____
Employer's phone number: _____
Relationship to patient: _____

INSURANCE INFORMATION

Name and address of primary insurance company_____
_____
Insurance company phone number: _____
Policyholder's first and last name: _____
Policyholder's date of birth: _____
Policyholder's employer: _____
Policy number: _____
Group number: _____
Policyholder's relationship to patient: _____

LOCAL FRIEND OR RELATIVE OTHER THAN LISTED ABOVE

Name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone number: _____
Relationship to patient: _____

REFERRED BY

Patient's primary care physician: _____
Referred to me by: _____
Reason for referral: _____
Previous therapy? _____
If so with whom? _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS.

I hereby authorize Dale B. Mortimer, M.D., P.C. to bill my insurance company and accept payment from that company on my behalf for all services. I hereby authorize Dale B. Mortimer, M.D., P.C. to provide my insurance company with any/all information requested concerning my present claims relating to my care. I acknowledge that I am responsible for all charges not covered by my insurance.

Responsible party's signature: _____ Date: _____

AUTHORIZATION TO PROVIDE REASONABLE AND PROPER MEDICATION CARE

Patient's signature: _____ Date: _____