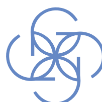

Joeanne Gutzwiller, Ph.D.
Child Psychology Services

2810 Mack Road, Fairfield, OH 45014-5130. (513) 874-4530

PATIENT REGISTRATION

Please print Date______________________________

Patient Name____ Home Phone______________________

Address________________________________City________________ State_______ Zip____________

Patient Birth Date______________________ Age_______ Sex_______ Marital Status ___S ___M ___D

Patient's Employer/School ________________________________ Work Phone____________________

May we call you at work? YES NO

Emergency Contact _______________________________ Emergency Phone____________________

Referred By ___________________________ Primary Care Physician ____________________________

Responsible for Bill (Responsible party must be present)

Name____ SSN_________________________

Address________________________________City________________ State_______ Zip____________

Home Phone___________________________ Relationship to patient___________________________

Employer____WorkPhone____________________

Cell Phone__________________________

Insurance Cardholder Information

Name____ Relationship to patient____________________

Address________________________________City________________ State_______ Zip____________

Home Phone__________________________________Work Phone______________________________

Employer____CellPhone_______________________________

Cardholder's Birth Date________________________Cardholder's SSN___________________________

Insurance Information

Primary Insurance Co.____ (where mental health clams are filed)

Address (Claims Office)_________________________________ City____________________ State_____

Zip_________________ ID# on card_______________________ Group/Plan#_____________________

Payer ID#___________________________ (Located on back of insurance card)

Secondary Insurance Co._____________________________________ (where mental health clams are filed)

Address (Claims Office)_________________________________ City____________________ State_____

Zip_________________ ID# on card_______________________ Group/Plan#_____________________

Payer ID#___________________________ (Located on back of insurance card)

As a service to our patients, we file claims with insurance companies. However, if payment is not received within 60 days of the claim, you, the patient (or person financially responsible for patient), will be responsible for payment. I authorize payment of insurance or government benefits to Joeanne Gutzwiller, Ph.D. I authorize the release of any medical or other information necessary to process insurance claims.

_________________________ ____

(Date) (Signature of patient, parents, or legal guardian)