DR. MELISSA KLASKIN, PHD, LCSW

PATIENT REGISTRATION FORM

PATIENT NAME_____**DATE OF BIRTH**_____

ADDRESS_____**CITY**_____**ZIP**_____

PHONE(HOME)_____**(CELL)**_____**(WORK)**_____

EMPLOYER_____**OCCUPATION**_____

EMPLOYER ADDRESS_____**CITY**_____**ZIP**_____

MAY I CALL HOME PHONE?_____ **WORK PHONE?**_____**CELL PHONE?**_____

SOCIAL SECURITY #_____

INSURANCE INFORMATION:
INSURED NAME_____
INSURANCE CO._____
INSURANCE CO. ADDRESS_____
INSURANCE CO. PHONE_____
INSURED'S EMPLOYER_____
EMPLOYER PHONE_____
RELATIONSHIP TO POLICY HOLDER_____
INSURED SOCIAL SECURITY #_____

GENERAL INFORMATION:
LOCAL RELATIVE_____RELATIONSHIP_____
ADDRESS_____
CITY_____PHONE_____
REFERRED BY_____PHONE_____
PERSON LEGALLY RESPONSIBLE FOR PAYMENT_____

***I AGREE TO ACCEPT RESPONSIBILITY FOR ALL CHARGES INCURRED. I UNDERSTAND THAT A 24 HOUR NOTICE OF CANCELLATION IS REQUIRED TO AVOID A CHARGE.
SIGNED_____DATE_____

ASSIGNMENT OF BENEFITS:
***I HEREBY AUTHORIZE MY INSURANCE CO. TO MAKE PAYMENT DIRECTLY TO DR. MELISSA KLASKIN FOR SERVICES RENDERED.

SIGNED_____DATE_____