

PSYCHIATRY OF TULSA, P.C.

PATIENT INFORMATION	PATIENT NAME (LAST, FIRST MIDDLE)			ALSO KNOW AS / MAIDEN NAME		SOCIAL SECURITY NUMBER		
	DATE OF BIRTH / /		AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> LEGALLY SEPERATED <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> LIFE PARTNER <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED			
	ADDRESS				CITY, STATE		ZIP CODE	
	PRIMARY PHONE		SECONDARY PHONE		PRIMARY CARE PHYSICIAN		PHYSICIANS PHONE	
	EMPLOYER				EMPLOYER PHONE		OCCUPATION	
	EMPLOYER ADDRESS				CITY, STATE		ZIP CODE	

INSURANCE	PRIVATE PAY <input type="checkbox"/> YES <input type="checkbox"/> NO RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> GUARDIAN (PLEASE LIST UNDER EMER CONTACT)			
	PRIMARY INSURANCE		SECONDARY INSURANCE	
	INSURANCE COMPANY NAME		INSURANCE COMPANY NAME	
	ID NUMBER	GROUP NUMBER	ID NUMBER	GROUP NUMBER
	POLICY HOLDER INFORMATION			
	NAME (LAST, FIRST MIDDLE)		RELATIONSHIP TO PATIENT	
	(POLICY HOLDERS) SOCIAL SECURITY NUMBER		(POLICY HOLDERS) DATE OF BIRTH / /	SEX <input type="checkbox"/> M <input type="checkbox"/> F
EMPLOYER		OCCUPATION		

EMERGENCY CONTACT	NAME (LAST, FIRST MIDDLE)		RELATIONSHIP TO PATIENT		
	ADDRESS		CITY, STATE		ZIP CODE
	PRIMARY PHONE	SECONDARY PHONE		EMPLOYER PHONE	

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES – A detail of your rights and how your medical information will be used and disclosed by Psychiatry of Tulsa, P.C. is set forth in the Notice of Privacy Practices. A copy has been furnished to me and is posted in the practice. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional service rendered. I have completed the above information. I request that payment of authorized medical benefits, if any, be made to Psychiatry of Tulsa, P.C. on my behalf for any unpaid services rendered by Psychiatry of Tulsa, P.C. I authorize the release of medical information to the health plan indicated for information requested by the health plan to determine the payment of medical benefits.

I acknowledge receipt of the Notice of Privacy Practices.

SIGNATURE

DATE