North Penn Neuropsychological Services

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****PLEASE FILL OUT THIS FORM COMPLETELY****

Patient Information

Patient First Name: _____ Middle Initial ____ Last Name_____

Preferred Pronoun: _____, Date of Birth: _____, SS#_____-_____-_____

Address: _____
(Street Address)

_____, ***email:** _____
(City, State, Zip)

Phone #: (H)_____ (C)_____ Is it okay to leave a detailed message? ***(Y / N)***

Emergency Contact: _____ Contact phone #_____

**Name of person(s) with whom we may discuss your treatment:* _____

Insurance Information

Employer: _____

Primary Insurance_____ ***Member ID #***_____

Is this a group plan ***(Y / N)***? Group #_____, Is this an employer-sponsored plan ***(Y / N)***?

Relationship to Policy Holder: (self/spouse/child/other) Policy Holder's Employer_____

Policy Holder's Name: _____, Policy Holder's Date of Birth: _____

Secondary Insurance_____ ***Member ID #***_____

Relationship to Policy Holder: (self/spouse/child/other) Policy Holder's Employer_____

Policy Holder's Name: _____, Policy Holder's Date of Birth: _____

Physician Contact Information

Primary Physician_____ Phone #_____ Fax #_____

Referring Physician_____ Phone #_____ Fax #_____

****I authorize North Penn Neuropsychological Services to obtain/release information to/from the above.****

Patient Signature (if minor, write "minor") _____ **Date**_____

Parent/Guardian Signature #1 (for minor patient) _____ **Date**_____

FOR PATIENTS UNDER 14 YEARS OF AGE (Required):
Per PA State Law, we must obtain the signatures of both Parents/Legal Guardians to administer testing to children under 14 years of age. If second parent is deceased, check this box: ☐

Parent/Guardian Signature #2 (for minor patient) _____ **Date**_____