CENTRAL ILLINOIS PSYCHIATRIC ASSOCIATES

Patient Information

APPOINTMENT DATE: _____

PROVIDER: ◉ Dr. Paturi

PATIENT NAME:_____ **PREFERRED NAME:** _____

PATIENT ADDRESS:_____ **CITY, STATE, ZIP:** _____

PATIENT DOB: _____ **PATIENT SSN:** _____

1st PHONE: _____ ○Home ○Work ○Cell **Is it okay to leave a message?** ○Yes ○No

2nd PHONE: _____ ○Home ○Work ○Cell **Is it okay to leave a message?** ○Yes ○No

PATIENT EMAIL: _____

SEX: ○ Male ○ Female **MARITAL STATUS:** ○ Single ○ Married ○ Divorced ○ Widowed **STUDENT:** ○ Full Time ○ Part Time ○ NA

How did you hear about CIPA: _____

Insurance & Billing Information

PRIMARY INSURANCE

INSURANCE COMPANY:_____ **INSURANCE CO PHONE #:** _____

POLICY ID #: _____ **GROUP #:** _____ **POLICY HOLDER NAME:** _____

POLICY HOLDER DOB: _____ **POLICY HOLDER SSN:** _____

POLICY HOLDER EMPLOYER: _____

POLICY HOLDER ADDRESS: _____

CITY, STATE, ZIP: _____ **PHONE #:** _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER ○ Self ○ Spouse ○ Child ○ Other: _____

SECONDARY INSURANCE

INSURANCE COMPANY:_____ **INSURANCE CO PHONE #:** _____

POLICY ID #: _____ **GROUP #:** _____ **POLICY HOLDER NAME:** _____

POLICY HOLDER DOB: _____ **POLICY HOLDER SSN:** _____

POLICY HOLDER EMPLOYER: _____

POLICY HOLDER ADDRESS: _____

CITY, STATE, ZIP: _____ **PHONE #:** _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER ○ Self ○ Spouse ○ Child ○ Other: _____

MINORS

RESPONSIBLE PARTY NAME: _____

ADDRESS: _____ **CITY, STATE, ZIP:** _____

PHONE #: _____ **DOB:** _____ **SSN:** _____

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY ○ Child ○ Other: _____

ALTERNATIVE ADDRESS (if different from patient):

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____ **PHONE #:**_____

RELATIONSHIP TO PATIENT:_____

EMERGENCY CONTACT (if we are unable to reach you):

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____**PHONE #:** _____

RELATIONSHIP TO PATIENT:_____

Assignment/Authorization: I hereby assign my insurance benefits to be paid directly to the provider. I am financially responsible for all services regardless of insurance coverage. I hereby authorize Central Illinois Psychiatric Associates to release any information they may obtain to my insurance company or their representatives.

SIGNED (PATIENT): _____ **DATE**: _____

IF UNDER 18, PARENT/GUARDIAN MUST SIGN ALSO

PARENT/GUARDIAN: _____ **DATE**: _____

WITNESS: _____ **DATE**: _____