Arnold Freedman, Ph.D., 1717 Penn Avenue, Suite 4000, Wilkinsburg, PA 15221

Patient Information **Date:** _____

Patient Name _____ Date of Birth _____

Patient Address _____ Social Security # _____

_____ Sex: Female ____ Male _____

_____ County: _____

Home Phone# (_____)_____ Work Phone# ( ) _____

Marital Status: Sin / Mar / Wid / Div e-mail address_____

Employer Name _____ Student: YES ____ NO _____

Employer Address _____

_____

_____

May we contact you at home? _____ May we contact you at work? _____

May we discuss your account with someone other than yourself? _____

If so, WHO? _____ Relationship _____

Insurance Information

1. Primary Ins _____ Subscriber _____

Insurance Address _____ Subscriber DOB _____

Insurance Telephone# _____

Policy# _____ Group# _____

DX 1: _____DX 2: _____DX 3: _____DX 4: _____

PLEASE READ AUTHORIZATION INFORMATION BELOW AND SIGN AND DATE BOTH SECTIONS. THANK YOU.

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to this provider who accepts assignment.

SIGNATURE_____DATE_____

I authorize payment of medical benefits to this provider for the services being provided.

SIGNATURE_____DATE_____