

New Patient

Change of info

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**Advanced Behavioral Healthcare**

PATIENT INFORMATION

Referred By: \_\_\_\_\_

First Date of Symptoms: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Relationship to Insured: Spouse/Parent/Child

Sex: Male/Female Marital Status: Single/Married/Divorce

Sex: Male/Female Marital Status: Single/Married/Divorce

Patient Social Security: \_\_\_\_\_

Insured Social Security: \_\_\_\_\_

Employment: Full/Part/Retired Date: \_\_\_\_\_

Employment: Full/Part/Retired Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ Policy # \_\_\_\_\_

Claim Mailing Address: \_\_\_\_\_ Group # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ Policy # \_\_\_\_\_

Claim Mailing Address: \_\_\_\_\_ Group # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_

**PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD**

**FOR OFFICE USE ONLY:**

**DIAGNOSIS:** \_\_\_\_\_

**ASSIGNED TO:** \_\_\_\_\_

**INSURANCE VERIFICATION: YES \_\_\_\_\_ NO \_\_\_\_\_**

**INSURANCE CO-PAYMENT AMOUNT \_\_\_\_\_ (PLEASE COLLECT AT EACH VISIT)**

**All scheduled appointments must be cancelled 24 hours before the session.  
Appointments not cancelled will be billed and will be the patient/guarantor's responsibility.**