WELCOME TO EB PSYCH SOLUTION, INC.
PATIENT INTAKE FORM

PATIENT INFORMATION

DATE ____________

Last ______________________ First ______________________ Middle Initial ________

Street Address ______________________ City ________________ State ________ Zipcode ____________

MAILING ADDRESS (If different)

Street Address ______________________ City ________________ State ________ Zipcode ____________

Tel. No. **Home** ( ) - **Work** ( ) - **Cell** ( ) -

Do you prefer we contact you at your: ( ) Home ( ) Work ( ) Cell

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced ( ) Separated

Sex: ( ) Female ( ) Male **Date of Birth:** _____/____/_____ **Age:** _____

SS#: _______-_______-_______ **DRIVERS LICENSE #:** ______________________

Employer: ______________________________ **Occupation** ______________________

EMERGENCY CONTACT INFORMATION

NAME: **Last** ____________________ **First** ____________________ **Middle Initial** ______

Address ____________________ **City** ____________________ **State** ________ **Zip** __________

Relationship to Patient ____________________ ( ) Home ( ) Work ( ) Cell ( ) -

INSURANCE INFORMATION
(Please present a copy of your insurance card at the front desk)

PRIMARY INSURANCE ____________________ **INSURED NAME** ____________________

SS#: _______-_______-_______ **Date of Birth:** _____/____/_____ **Sex:** ( ) Female ( ) Male

Address ____________________ **City** ____________________ **State** ________ **Zip** __________

Ins. ID # **Group #** **Tel. No.** ( ) -

SECONDARY INSURANCE ____________________ **INSURED NAME** ____________________

SS#: _______-_______-_______ **Date of Birth:** _____/____/_____ **Sex:** ( ) Female ( ) Male

Address ____________________ **City** ____________________ **State** ________ **Zip** __________

Ins. ID # **Group #** **Tel. No.** ( ) -

YOUR CO-PAY IS DUE AT THE TIME OF SERVICE. THANK YOU!

REFERRED BY: ______________________________

PRIMARY CARE MD: ____________________ **Telephone No.** ( ) -

PREFERRED PHARMACY ____________________ **Telephone No.** ( ) -

Address ____________________ **City** ____________________ **State** ________ **Zip** __________

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to **EB Psych Solution, Inc.** for any services rendered to me by **Dr. Enrico Balcos, MD**.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare / Other Insurance Company assigned cases, the physician accept the charge determination of the Medicare / Other Insurance Company as the full charge (excluding non-contracted insurance) and the patient is only responsible for the deductible, co-insurance, co-payment or non-covered services.

PATIENT SIGNATURE ____________________ **PRINT NAME** ____________________ **DATE** ____________

GUARDIAN SIGNATURE
(If under the age of 18) ____________________ **PRINT NAME** ____________________ **DATE** ____________