

# NEUROBEHAVIORAL MEDICINE GROUP

## OUTPATIENT INFORMATION ADULT

Patient Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Email Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Cell # \_\_\_\_\_ Other # \_\_\_\_\_

Relationship of Emergency Contact to Patient \_\_\_\_\_

Responsible Party for Payment \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

*We are private pay but in the case of needing prior authorizations for medications, please provide the following insurance information:*

Health Insurance and I.D. # \_\_\_\_\_

Prescription Insurance and I.D. # \_\_\_\_\_

Prescription Prior Authorization tel. # \_\_\_\_\_

Referred to this Office By \_\_\_\_\_

Current Medications and Prescribing Physician \_\_\_\_\_

\_\_\_\_\_

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