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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