**Your name: date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Referred by :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 AGE:\_\_\_\_\_\_\_BIRTH DATE:\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BUSINESS PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOBILE PHONE: :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-MAIL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DRIVER’S LICENSE #

***IN CASE OF AN EMERGENCY***

 ***I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(your name) waive the privilege, release confidentiality, and***

***give Dr. Drozd permission to contact the following persons on***

***my behalf. Your Signature/Date***

***(1)*** Name**\_\_\_\_\_\_\_\_\_\_**  Relationship to you\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BUSINESS PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOBILE PHONE: :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***(2)*** Name Relationship to you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BUSINESS PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_FAX:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOBILE PHONE: :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

***Your CURRENT PARTNER* if applicable** (or if already listed above under someone to contact

in case of an emergency, please simply say “See (1) above or See (2) above.

HOME PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_BUSINESS PHONE:\_\_\_\_\_\_\_\_\_\_FAX:\_\_\_\_\_\_\_\_\_ MOBILE PHONE: \_\_\_\_\_\_\_\_\_\_\_

E-MAIL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Others living in your household including ages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**If the patient is an Adult, Children’s Names and Dates of Birth:**

& \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name): age \_\_\_ (DOB\_\_\_\_\_\_) and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name): age \_\_\_ (DOB\_\_\_\_\_\_\_\_\_)

& \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name): age \_\_\_ (DOB\_\_\_\_\_\_) and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name): age \_\_\_ (DOB\_\_\_\_\_\_\_\_\_)

If the patient is a child, please provide the name of the other parent and contact information

regarding that parent and whether you two have joint or sole legal custody of your child. \_\_\_\_\_

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**If applicable, please provide your Insurance Information.**

Carrier\_\_

Name of Primary Insured & Date of Birth

Your relationship to the insured: Primary Insured’s ID #

Insurance Plan Name or Program Name

Insurance’s Billing Address

Primary Insured’s Employer & Policy or FECA Number

Primary Insured’s address/phone #

PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE. I authorize the release of any medical or other information if necessary to process an insurance claim. I also authorize payment of benefits to either

myself or the person who accepts an assignment of benefits. Signed Dated

INSURED’S OR AUTHORIZED PERSON’S SIGNATURE. I authorize payment of medical benefits to Leslie M. Drozd, Ph.D. Signed Dated