DANIEL LEGERSKI, PSY.D., L.P., LLC

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PATIENT REGISTRATION FORM

PATIENT'S NAME_____ **AGE**_____ **DOB**_____/_____/_____

ADDRESS_____
STREET *CITY* *ZIP*

SEX: ☐ **Female** ☐ **Male** ☐ **Nonbinary** **Preferred Prononouns:** _____

MARITAL STATUS: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated** ☐ **Other**

SOCIAL SECURITY # _____ **HOME PHONE ( )** _____

EMPLOYER _____ **WORK PHONE ( )** _____

OCCUPATION_____ **CAN YOU BE CALLED AT WORK?**_____

NAME OF REFERRAL SOURCE:_____

IN CASE OF EMERGENCY CONTACT:_____ **RELATIONSHIP:**_____

HOME PHONE ( ) _____ **WORK PHONE ( )** _____

FINANCIALLY RESPONSIBLE PARTY (Guarantor)
If Different Than Above

NAME_____ **RELATIONSHIP TO PATIENT**_____

ADDRESS_____ **HOME PHONE ( )** _____
EMPLOYER_____ **WORK PHONE ( )** _____
OCCUPATION_____

INSURANCE INFORMATION

INSURANCE COMPANY NAME, ADDRESS AND PHONE	POLICY # (ID #)	GROUP #	NAME OF POLICY HOLDER	POLICY HOLDER S.S.# & BIRTHDATE
PRIMARY	DEDUCTIBLE:	COPAY:		
SECONDARY	DEDUCTIBLE:	COPAY:		

I authorize Daniel Legerski, Psy.D., L.P., LLC to release information regarding assessment and treatment to my insurance company for the purpose of supporting my need for care and for receiving the benefits due to me. I hereby authorize direct payment to the above provider of any and all benefits for charges for examination and/or treatment received by me or my dependents.

Signature_____ **Date**_____

(Circle if Parent or Guardian)