Patient Registration – **Child**

Sandra F. Pfander, Psy.D.

Patient Name: _____ Nickname: _____

Date of Birth ____/____/_____ Male ___ Female ___

Address: _____ City: _____Zip Code: _____

Telephone: Home/Cell # _____

Mother: _____ Address: _____

Date of Birth: ___/____/____ Employer: _____

Father: _____ Address: _____

Date of Birth: ___/____/____ Employer: _____

Primary Care Physician: _____ City: _____

Food/ Drug Allergies: _____

INSURANCE INFORMATION:

Primary Insurance

Name of Insurance Company: _____
Employer: _____
Subscriber/ Policy Holder: _____ Date of Birth: ____/____/____
Contract/Policy #: _____
Group/Plan #: _____

Secondary Insurance:

Name of Insurance Company: _____
Employer: _____
Subscriber/ Policy Holder: _____ Date of Birth: ____/____/____
Contract/Policy #: _____
Group/Plan #: _____

Insurance Authorization:

I hereby authorize Dr. Pfander to furnish information to my insurance carriers concerning my diagnosis and treatment, and I hereby assign to the psychologist all payments for services rendered to myself or dependents. I understand that I am responsible for any amount not covered by insurance.

HIPAA:

I have read the HIPAA Office Policies. They are posted on the website or in office. _____ **(initial)**.

Date: _____ Signature: _____

Witness: _____