

Patient Registration – **Child**

Steven G. Haupt, Ph.D.

Patient Name: _____ **Nickname:** _____

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

Address: _____ City: _____ Zip Code: _____

Phone: Cell _____ Home: _____

Mother: _____ **Address:** _____

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

Father: _____ **Address** _____

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

Primary Care Physician: _____ **City** _____ **Phone:** _____

Food/ Drug Allergies:

INSURANCE INFORMATION:

Primary Insurance: Insurance Company: _____

Employer: _____

Subscriber/PolicyHolder: _____ Date of Birth: ____/____/____

Contract/Policy#: _____ Group/ Plan #: _____

Secondary Insurance: Insurance Company: _____

Employer: _____

Subscriber/PolicyHolder: _____ Date of Birth: ____/____/____

Contract/Policy#: _____ Group/Plan#: _____

Insurance Authorization: I hereby authorize Dr. Haupt 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 our website and in our office _____

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Date: _____ Signature: _____

Witness: _____