S. W. ZIMOSTRAD, Ph.D. AND ASSOCIATES

CLINICAL AND BEHAVIORAL NEUROPSYCHOLOGY

720 W. Wackerly St., Midland, MI 48640 *Ph: 989.839.6565* Fax: 989-839-5794 * 4957 W. M-72, Grayling, MI 49738

PATIENT INFORMATION (please print)

PATIENT NAME (LAST-FIRST-MIDDLE) DATE OF BIRTH AGE MARITAL STATUS

ADDRESS (STREET-CITY-STATE-ZIP) HOME PHONE

EMERGENCY CONTACT NAME RELATIONSHIP HOME/WORK PHONE

FAMILY PHYSICIAN ADDRESS PHONE

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? PHONE

WHOM MAY WE THANK FOR REFERRING YOU TO US?

INSURANCE INFORMATION

PRIMARY INSURANCE NAME PHONE NUMBER ADDRESS

NAME OF INSURED S.S. NUMBER DOB NAME OF EMPLOYER PHONE

ID NUMBER GROUP NUMBER RELAITONSHIP TO PATIENT

SECONDARY INSURANCE NAME PHONE NUMBER ADDRESS

NAME OF INSURED S.S. NUMBER DOB NAME OF EMPLOYER PHONE

ID NUMBER GROUP NUMBER RELAITONSHIP TO PATIENT

INSURANCE INFORMATION AND AUTHORIZATION

I, the undersigned, certify that I (or my dependent) have insurance with _____ and

Assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship Date