

Center for the Treatment of Eating Disorders

A specialized professional resource

PATIENT INFORMATION

(All information is regarded as confidential)

(PLEASE PRINT CLEARLY)

TODAY'S DATE: _____

REVISED DATE: _____

REFERRED BY: _____

NAME _____ BIRTH DATE _____
(Last) (First) (Middle)

SOCIAL SECURITY _____ MARITAL STATUS _____

ADDRESS _____ ZIP CODE _____
(Street) (City)

PHONE # (Home) _____ (Cell) _____ (Work) _____

EMPLOYER _____ ADDRESS _____

NAME OF SPOUSE/PARENT _____ ADDRESS _____

SOCIAL SECURITY # OF SPOUSE/PARENT _____ PHONE _____

CHIEF COMPLAINT/ REASON FOR VISIT:

DATE OF LAST GENERAL PHYSICAL _____ DO YOU HAVE HIGH BLOOD PRESSURE _____

LIST ALL ALLERGIES (DRUG/FOOD/HAY FEVER/OTHER)

LIST ALL MEDICATIONS YOU ARE TAKING:

DESCRIBE ANY CONDITIONS WE SHOULD KNOW ABOUT:

ARE YOU CONSULTING A DOCTOR DUE TO AN ACCIDENT? _____

PRIMARY INSURANCE COMPANY _____ POLICY # _____

NAME OF INSURED _____ SOCIAL SECURITY # _____

INSURANCE THROUGH EMPLOYER _____ IF YES, ID# _____ GROUP # _____

SECONDARY INSURANCE _____ COMPANY NAME _____
CLAIM FORM SUPPLIED _____ STANDARD FORM ACCEPTED _____

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ADDRESS TO SEND CLAIM _____

I understand that I am financially responsible for all charges for services rendered to me, including the balance remaining after payment of possible insurance benefit.

Signed: _____ Date _____
(Patient/Parent if Minor)

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to myself or the names provided for professional services rendered.

Signed: _____ Date _____
(Patient/Parent if Minor)

RELEASE OF INFORMATION

I authorize the release of any medical information to process this claim.

Signed: _____ Date _____
(Patient/Parent if Minor)