

NORTH SHORE CONSULTATION CENTER

New Patient Information

Date _____ Dr. _____

Patient Name _____ Age _____ Date of Birth _____

Address _____ City _____ Zip _____

Phone #s Home _____ Cell _____ Work _____

Email address _____

School _____ Grade _____

Physician _____ Phone # _____

Custodial Parent(s)' Name _____

Billing Address (if different from above) _____

Medical conditions for which the patient is taking prescription medication:

1-Medical Diagnosis _____ Medication & Dosage _____

2-Medical Diagnosis _____ Medication & Dosage _____

Insurance Co _____ Insured's ID _____ Group # _____

Insurance Co address _____ Phone# _____

Insured's Name _____ Insured's Date of Birth _____

Referral source _____

ALL INSURANCE PRE-CERTIFICATION IS THE RESPONSIBILITY OF THE INSURED.

I understand that I am responsible for the payments of all services. Any expenses incurred to collect payments are also my responsibility.

Signature _____ Date _____