NORTH SHORE CONSULTATION CENTER
New Patient Information

Date_____ Therapist_____

Patient Name_____ Age_____ Date of Birth_____

Address_____ City_____ Zip_____

Phone #s Home_____ Cell_____ Work_____

Email address_____

School_____ Grade_____

Physician_____ Phone #_____

Psychiatrist_____ 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_____

Referral source_____

Insurance Information

Insurance Company _____ Insured's ID_____ Group #_____

Insurance Company address_____ Phone #_____

Insured's Name_____ Insured's Date of Birth _____

Patient Relationship to the insured: __ Self __ Spouse __ Child __ Other

Employer _____

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_____