Laura E. Forsyth, Ph.D.

INSURANCE REGISTRATION FORM

Today's Date:					
PATIENT INFORMATION					
Patient's last name:		First:		Middle:	
Marital/relationship status: Single ☐ LTR ☐ Mar/Part ☐ Div ☐ Sep ☐ Wid ☐					
Is this your legal name? ☐ Yes ☐ No	If not, your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F
Street address:		Social Security no.:	Home phone no.: ( )		
P.O. box:	City:		State:	ZIP Code:	
Occupation:	Employer:		Employer phone no.: ( )		
Referred by:	☐ Dr.	☐ Insurance	☐ Hospital		
☐ Family	☐ Friend	☐ Online directory	☐ Other		
INSURANCE INFORMATION					
Person responsible for bill:	Address (if different):		Phone no.: ( )		
Insurance Company & type of plan (HMO, PPO, etc.)			Phone no.: ( )		
Subscriber's name:	S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-pay: $
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Doctor:	Doctor's address:		Doctor's phone no.: ( )		
Psychiatrist:	Psychiatrist's address:		Psychiatrist's phone no.: ( )		
EMERGENCY CONTACT					
Name of local friend or relative:	Relationship to you:	Home phone no.: ( )	Work phone no.: ( )		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Laura Forsyth. I understand that I am financially responsible for any balance. I also authorize Dr. Forsyth or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*