J. Gary Dolinsky, Ph.D.
Licensed Psychologist Provider

161 South Main Street, Suite 309
Middleton, MA 01949
(978) – 750 – 1990 phone
(978) – 739 – 4042 fax

jgdol@aol.com
www.jgarydolinskyphd.com

Patient Registration

TODAY'S DATE: _____________

FIRST NAME: _________________ LAST NAME: _________________ MAIDEN: __________

STREET/APT. #: ______________________ CITY: _________________ STATE: _____ ZIP:____

AGE:____________ DATE OF BIRTH:___________MARITAL STATUS:___________

OCCUPATION/POSITION:____

EMPLOYER/SCHOOL: ____

HOME PHONE: __________________________ WORK PHONE: _________________________

CELL PHONE: ____________________________ FAX:_____________ EMAIL:_____________

EMERGENCY CONTACT PERSON: ___________________ RELATIONSHIP:_______________

HOME PHONE: __________________ WORK PHONE: _____________ CELL:_____________

How did you learn about my practice? ____

REFERRED BY:______________________________ PHONE:_________________ FAX:_______

ONLY complete if you are planning to use insurance (must provide copy both sides of your insurance card)

INSURANCE COMPANY: ____________________ INSURANCE ID#:___________________

INSURANCE PHONE #:_______________________ ADDRESS: _______________________

NAME OF INSURED (if other than you):_____________________ DATE OF BIRTH: _______

EFFECTIVE SINCE: ____________________CARD PHOTOCOPY INCLUDED both sides Y / N

MY INSURANCE (check all that apply):

___ Has a yearly deductible……………. Amount _______________________________
___ Has a co-payment…………………… Amount________________________________
___ Has a yearly allowance……………….Amount________________________________
___ Requires prior authorization…. Is this obtained: Y / N Number of visits _______

___ Is there any secondary insurance? Y / N

Primary Care Physician ____

Address____

PERSON REPONSIBLE FOR BILL (if other than you): _________________________________

ADDRESS: ____

Insurance authorization and assignment: I hereby authorize the provider of services to furnish Information to my **Primary Care Physician AND Insurance Carriers** concerning my condition and treatment, and I hereby assign to the provider all payments for medical services rendered to myself or my dependents. I understand it is my responsibility to pay any **Deductible Amount**, co-payment (s) or other allowable balance not paid for by my insurance.

DATE:_____________________ SIGNATURE:____________________________________