

Ann E. Drouilhet, L.I.C.S.W.
40 Speen Street
Framingham, MA 01701

NEW PATIENT INFORMATION

Date: _____

Patient Information:

Name _____ <small>First MI Last</small>			
Address _____		APT# _____	Cell# _____
City _____		State _____	Zip _____ Telephone # () _____
SS# _____	Sex - M or F	Birthdate _____	Marital Status - M; S; D; W
Email: _____			
Referred By: _____		Medications: _____	
Physician: _____		Past Hospitalizations: _____	
<i>In the event of an emergency please contact:</i>			
Name: _____		Phone: _____	Relationship: _____

School Information:

School Name _____	Phone # _____	Grade _____
Address _____		City _____ State _____ Zip _____

Employment Information:

Employment: - F - P/T - Retired - Not Employed - <i>(circle one)</i>		
Employer _____	Phone () _____	- _____
Address _____		City _____ State _____ Zip _____

Family Members:

Name	DOB	Address & Phone (home & work)
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____

Please be sure to turn over the form and complete the other side. Thank you !

Insurance Information - Insurance # 1

Insurance Plan Name _____

Address _____ City _____ State _____ Phone _____

Subscriber Name _____ ("Same" if same as patient)

Subscriber Address _____ ("Same" if same as patient)

Relationship to Patient _____ Subscriber DOB _____

Subscriber ID# _____ Group# _____ Policy# _____

Guarantor _____ Precertification # _____ Co-Pay. _____

Diagnosis code: _____

PATIENT or AUTHORIZED PERSON'S SIGNATURE REQUIREMENTS

PLEASE READ AND SIGN All SECTIONS

Release of Information

I (patient, parent or guardian) authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed _____ Date _____
(Patient/authorized person)

Assignment of Benefits

I authorize payment of medical benefits to Ann E. Drouilhet, L.I.C.S.W.

Signed _____ Date _____
(Patient/authorized person)

Cancellation Policy

I request that you give me at least 24 hours notice if you must cancel an appointment. If you must cancel on short notice for unavoidable reasons, please call to let me know that you are not coming. I charge my usual fee for unnecessary cancellations or missed appointments. Please be aware that insurance companies will not pay for canceled or missed appointments.

I have read and understand the cancellation policy.

Signed _____ Date _____
(Patient/authorized person)