SOUTHEAST PSYCHIATRY
Paul Topol, M.D.
2 Marine Way, Suite 204 ♦ Juneau, AK 99801
907.209.8962 southeastpsychiatry@gmail.com

Date: ________________

NEW PATIENT INFORMATION

Patient's Full Name (including any initials):	Marital Status: (Circle) S M W DIV SEP	Gender: (Circle) F M	Date of Birth: mm/dd/yyyy

Mailing Address: __ Perm ___ Temp	City / State:	Zip Code:	Home Phone:	Cell Phone:	Work Phone

Occupation of Patient	Patient's Employer:	Email Address:	Social Security Number:

How did you first find out about the practice?	Primary Care Physician:	Referring Physician's full name:

INSURANCE COVERAGE

[List all carriers including Medicaid and Medicare -- If Self-pay, note so under first insurance carrier]

Insurance Company Name	I.D. Number:	Group Number:

Policy Holder Name on Insurance Card	Relationship to Patient	Insurance Policy Holder's Date of Birth and Social Security Number:

Insurance Company Name	I.D. Number:	Group Number:

Policy Holder Name on Insurance Card	Relationship to Patient	Insurance Policy Holder's Date of Birth and Social Security Number:

Insurance Company Name	I.D. Number:	Group Number:

Policy Holder Name on Insurance Card	Relationship to Patient	Insurance Policy Holder's Date of Birth and Social Security Number:

IF THE PATIENT IS A MINOR OR STUDENT / EMERGENCY CONTACT

Name of person/agency financially responsible for patient:	Relationship to patient:	Social Security Number:

Responsible person/agency mailing address and phone number:	If person for emergency contact is different than financial responsibility, please note:

PHYSICIANS RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Southeast Psychiatry for care of benefits due to me from my insurance company otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim or as required by law. I request payment of medical insurance benefits either to myself or to Southeast Psychiatry who accepts assignment. **I understand that I am financially responsible for charges regardless of coverage. All deductibles, co-payments, co-insurance's and other balances are paid at the time services are rendered.**

Patient's/Guarantor's Signature:	Date: