Cognitive Care
SOLUTIONS
Comprehensive Cognitive Wellness

New Patient Form

Date_____

PLEASE PRINT

Client Name_____

Address_____

City_____ **State** _____ **Zip Code** _____

Home Phone # _____ **Cell Phone #** _____**Email**_____

Age _____ **Date of Birth** _____ **Social Security #** _____

Primary Contact Name & Relationship_____

Contact Phone # _____ **Other Phone #** _____

Neurologist_____ **Primary Care** _____

Cognitive Diagnosis_____ **Mental Health Diagnosis**_____

Other Medical Conditions_____

Primary Insurance _____ Policy #_____

Secondary Insurance _____ Policy # _____

Name of Insured (if different than client)_____

Relationship to Patient _____

SSN of Insured (if different than Client)_____**DOB**_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize any holder of medical information about me to release said information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided or benefits for related services. **I request that you file insurance claims for the services rendered, and will provide all necessary information for you to do so. YES_☐_ NO _☐_.***

ASSIGNMENT OF BENEFITS: I Hereby authorize payment of benefits be made directly to the Practitioner for services provided to me by the Practitioner.

_____ _____

Signature of Patient Date Witness Date

If minor or dependent adult, signature of responsible person.