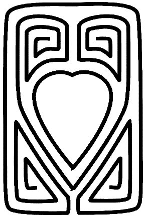

Rees Chapman, Ph.D.
Licensed Clinical Psychologist

40 Cosens Lane
Dahlonega, Georgia 30533
office 706-864-0695
website www.DrChapman.org

PATIENT INFORMATION:

Name_______________ Social Security #___ ___ ___ - ___ ___ - ___ ___ ___ ___
Address_______________ City_______________State______Zip_______
Home Telephone ( )_______________ Date of Birth____/____/____ Gender ◯male ◯female
Email _______________ Employer_______________◯full ◯part
Marital Status_______________ Work Telephone ( )_______________
Who referred you?_______________

RESPONSIBLE PARTY INFORMATION:

Name_______________ Social Security #___ ___ ___ - ___ ___ - ___ ___ ___ ___
Address_______________ City_______________State______Zip_______
Home Telephone ( )_______________ Date of Birth____/____/____ Gender ◯male ◯female
Email _______________ Employer_______________◯full ◯part
Marital Status_______________ Work Telephone ( )_______________

PRIMARY INSURANCE CARRIERS:

Company_______________ Telephone ( )_______________
Address_______________ City_______________State______Zip_______
Policy #_______________ Group #_______________
◯Medicaid ◯Medicare ◯HMO ◯PPO ◯Capitated ◯Champus ◯Other

SECONDARY INSURANCE CARRIERS:

Insured's Name_______________ Social Security #___ ___ ___ - ___ ___ - ___ ___ ___ ___
Date of Birth_______________ Relationship_______________
Employer_______________ Marital Status_______________
Insurance Company_______________ Telephone ( )_______________
Address_______________ City_______________State______Zip_______
Policy #_______________ Group #_______________
◯Medicaid ◯Medicare ◯HMO ◯PPO ◯Capitated ◯Champus ◯Other

EMERGENCY NOTIFICATION/NEXT OF KIN:

Name_______________ Relationship_______________
Address_______________ City_______________State______Zip_______
Home Telephone ( )_______________ Work Telephone ( )_______________

RELEASE OF AUTHORIZATION:

I authorize the release of any medical information necessary to process my insurance claim(s). I agree that this authorization will cover all services rendered by Dr. Chapman until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

_______________________________ ________/________/________
signature (patient or responsible party) date