**Rees Chapman, Ph.D.**
Licensed Clinical Psychologist

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Dahlonega, Georgia 30533
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**PATIENT INFORMATION:**

Name_____ Social Security #___ ___ ___ - ___ ___ - ___ ___ ___ ___
Address_____ City_____State_____Zip_____
Home Telephone (  )_____ Date of Birth____/____/____ Gender ◯male ◯female
Email _____
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