Cogent Psychiatric Services

Certification of the New Patient Information

Personal Information	(Please Print)		(Please Print)
Patient Name		Social Security #	
Home Address		Date of Birth	
City		Telephone (Home)	
State & Zip Code		Telephone (Work)	
Email Address		Telephone (Cell)	

Employment Information	(Please Print)		(Please Print)
Employer (or School)			
Address		Telephone	
City		State & Zip Code	

Payment Information	(Please Print)		(Please Print)
Payment Responsibility		Method of Payment	Insurance Plan
Name of Contact		(Please Circle One)	Self-Payment
Insurance Company		Authorization #	
Insurance Plan		Insurance ID #	
Insured Individual		Insured SSN	
Relationship to Insured		Insured Date of Birth	
Address		Employer	
City		Telephone (Home)	
State & Zip Code		Telephone (Work)	
Email Address		Telephone (Cell)	

Emergency Information	(Please Print)		(Please Print)
Primary Physician		Telephone	
Emergency Contact		Relationship	
Telephone (Cell)		Telephone (Home)	

Referral Information	(Please Print)		(Please Print)
Referred By		Physician	
Insurance Company		Friend	
Employer		Other	

Authorization, Permission, and Affirmation

I authorize the release of any medical information necessary to process this claim.

I permit a copy of this authorization to be used in the place of the original document.

I certify and affirm that the information I have reported is true, current, and accurate to the best of my knowledge.

Patient Name		Date	
Patient Signature			