NEW PATIENT INFORMATION

Thank you for choosing this office! In order to serve you properly, we need the following information. Please print.

Name_____ Male ☐ Female ☐
SS#/SIN _____ Birthday _____
Home Phone _____ Cell Phone _____
Address _____
City _____State_____ Zip _____
Minor ☐ Single ☐ Married ☐ Separated ☐ Divorce ☐
Widowed ☐ Other ☐
Patient or parent's employer _____
If student, name of school /college _____
Primary Care Physician _____
Emergency Contact/ Phone _____
Email _____

Insurance Information

Name of Insured_____
Relationship to Patient _____ Birthday _____
SS#/SIN_____Name of Employer _____
Work Phone _____
Address of Employer _____-_____
Insurance Company _____ID# _____
Group # _____

Do you have any additional insurance? ☐Yes ☐ No
If yes, please complete the following
Name of Insured_____
Relationship to Patient _____ Birthday _____
SS#/SIN_____ Date Employed _____
Name of Employer _____Work Phone _____
Address of Employer _____
Insurance Company _____ ID # _____
Group# _____

I authorize release of any information concerning my or my child's healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to Teresa Gregory Ormand, LISW-CP, 114 Williams St., Suite 101, Lancaster, SC 29720.

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Signature of Patient or parent/guardian Date