WILLIAM T. GOLDMAN, M.D., PA
Adult and Pediatric Psychiatry
Diplomate of the American Board of Psychiatry and Neurology
542 Silicon Dr., Suite #100 Southlake, Texas 76092
(817) 329-3300 Office (817) 329-3312 Fax

PATIENT REGISTRATION (SIDE 1)

Today's Date _____

Patient Name _____ Male / Female

Patient's SS # _____ Age _____ DOB _____

Marital Status: Single / Married / Divorced / Separated / Widowed

Address _____

City _____ State _____ Zip _____

Home Phone (___) _____ Work Phone (___) _____ Pager (___) _____

Preferred Contact Number: Home / Work / Pager Driver's License # _____

Referral Source _____ Phone (___) _____

Emergency Contact: _____ Phone (___) _____

Relation to Patient _____

Party Responsible for Payment (if different from Patient) _____

Address _____

City _____ State _____ Zip _____

Home Phone (___) _____ Work Phone (___) _____ Pager (___) _____

Relation to Patient _____

Is Patient a Minor? YES / NO**

Parent or Legal Guardian Name _____

Address _____

City _____ State _____ Zip _____

Home Phone (___) _____ Work Phone (___) _____ Pager (___) _____

****** IF PATIENT IS A MINOR, PARENT/LEGAL GUARDIAN MUST SIGN BELOW TO ACKNOWLEGE PERSONAL GUARANTEE FOR SESSION CHARGES EVEN IF PARENT IS NOT PRESENT AT THE TIME OF SERVICE******

I AGREE TO THE ABOVE _____ Date: _____

Print Name: _____

PATIENT REGISTRATION (SIDE 2)

PRIMARY INSURANCE CARRIER

Insurance Company Name: _____Policy Holder _____

Claims Mailing Address: _____

Insurance Phone Number: (___) _____ Pre-Authorization Number: _____

In Network/ Out of Network Effective Date of Coverage: _____

Group #: _____ Plan #: _____ Policy # _____

Insured Party's Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer _____ Work Phone (____) _____

SS # _____ Patient's Relationship to Insured Named Above: _____

**** NOTICE: YOU MUST GIVE 24 HOURS NOTICE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT TO AVOID BEING CHARGED FOR THE RESERVED TIME. NOTE THAT INSURANCE WILL NOT PAY FOR THIS MISSED APPOINTMENT CHARGE.**

RESPONSIBILITY FOR PAYMENT: I understand that **I am ultimately responsible for payment** to William T. Goldman, MD for charges for the above Patient, regardless of the actions of my Insurance Company.

Signature of Patient/Insured: _____ Date: _____