PATRICK B. ELLIS, D.O.

PSYCHIATRY

&

NUTRITIONAL MEDICINE

520 24th Ave. S.W. •Norman, OK 73069
Office 405-701-5666 • FAX 405-701-5667

Date: _____

Referred by: _____

Patient Name: _____

Street Address: _____ _____City_____ST_____Zip_____

Sex: _____ Birth Date: _____Marital Status: _____Social Security #: __ _____

Employer: _____ Work Phone: _____

Home Phone:_____ Cell Phone: _____

If insurance does not pay your bill, who is financially responsible for the balance?

Name: _____ Street Address: _____

City: _____State:_____ Zip: _____

INSURANCE INFORMATION

#1 Insurance Company:_____Policy #: _____

Policy Holder's Name: _____ DOB: _____

Social Security #: _____ Mail insurance claim forms to: _____

#2 Insurance Company:_____Policy #: _____

Policy Holder's Name: _____DOB: _____

Social Security #: _____ Mail insurance claim forms to: _____

Name and address of policy holder's employer: _____

_____ Policy holder's work phone: _____

AUTHORIZATIONS AND AGREEMENTS

Payment Policy and Cancellation Agreement: I understand that the office files my primary insurance as a courtesy, but the bill is MY responsibility. **I am aware that notice of cancellation must be given 24 hours in advance so that I will not be charged.**

Patient's Signature: _____

Release of Information and Assignment of Benefits Agreement: I authorize Patrick B. Ellis to release any information acquired in the course of my treatment to my insurance company and assign the insurance payment due to Patrick B. Ellis.

Patient's Signature: _____