

JOAN L. MOREAU, M.D.
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LEWISBURG, PA 17837
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PATIENT INFORMATION SHEET

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PH: _____ WORK PH: _____ CELL PH: _____

BD: _____ AGE: _____ SS#: _____

GENDER: MALE FEMALE STATUS: SINGLE MARRIED DIVORCED WIDOWED

REFERRED BY: _____ NAMES(S) OF PARENT(S): _____

EMERGENCY CONTACT: _____ EMERGENCY PHONE: _____

PRIMARY INS: _____ SECONDARY INS: _____

INSURED NAME: _____ INSURED NAME: _____

RELATIONSHIP: _____ BD: _____ RELATIONSHIP: _____ BD: _____

POLICY NO: _____ POLICY NO: _____

GROUP NO: _____ GROUP NO: _____

COPAY AMOUNT: _____ COPAY AMOUNT: _____

EMPLOYER: _____ EMPLOYER: _____

GUARANTOR (OWNER/SUBSCRIBER OF INSURANCE POLICY OR INDIVIDUAL WHO IS GUARANTEEING PAYMENT):

FULL NAME: _____ BD: _____

ADDRESS: _____ SS# _____

CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP TO PATIENT: _____

HOME PH: _____ WORK PH: _____ CELL PH: _____

PATIENT'S AUTHORIZATION

I authorize Joan L. Moreau, M.D. and her staff to apply for benefits on my behalf for services rendered by Joan L. Moreau, M.D. I request payment from my insurance company be made directly to Joan L. Moreau, M.D. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical and/or mental health information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical and/or mental health services provided, when a statement is rendered on my behalf.

I, the undersigned, voluntarily authorize and consent to any service, including but not limited to psychiatric evaluation and treatment, which is deemed necessary by Joan L. Moreau, M.D., for me or my child, if my child has been identified as the patient.

SIGNATURE OF SUBSCRIBER OR BENEFICIARY

DATE