Nicole Flory, PhD

Licensed Psychologist

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Patient Registration

FIRST NAME: _____ LAST NAME: _____ MAIDEN NAME: _____

STREET/APT #: _____ CITY: _____ STATE:_____ ZIP: _____

AGE: _____ DATE OF BIRTH: _____ MARITAL STATUS: _____

OCCUPATION / POSITION: _____

EMPLOYER / SCHOOL: _____

What / When (AM / PM) is your preferred way to reach you and leave a message? (complete all that apply)

HOME PHONE: AM PM _____ WORK PHONE: AM PM _____

CELL PHONE: AM PM _____ EMAIL: _____

How did you learn about my practice? _____

REFERRED BY: _____ PHONE: _____ FAX:_____

STREET: _____ CITY: _____ STATE: _____ ZIP: _____

Is it ok to send a "Thank you note"? YES NO

May I send you an occasional newsletter from my practice? YES NO

REASONS TO SEEK THERPY: _____

_____

_____

CURRENT HEALTH CONCERNS: _____

_____

_____

CURRENT MEDICATIONS: _____

_____

_____

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OVER-THE-COUNTER/HERBAL REMEDIES: _____

_____

_____

Other Information: _____

_____

_____

ONLY complete, if you are planning to use INSURANCE (must provide copy both sides of insurance card).
You should call your plan administrator to obtain an authorization letter (my NPI # is 144-740-7358).

AUTHORIZATION #:_____

INSURANCE COMPANY: _____ INSURANCE ID #: _____

INSURANCE PHONE NUMBER: _____ ADDRESS: _____

_____

NAME OF INSURED (if other than you):_____DATE OF BIRTH:_____

EFFECTIVE SINCE WHEN: _____CARD PHOTOCOPY INCLUDED (both sides): YES NO

PERSON RESPONSIBLE FOR BILL (if other than you): _____

ADDRESS: _____

EMERGENCY CONTACT PERSON: _____ **RELATIONSHIP:** _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

Patient's Signature: _____ Today's Date: _____

Patient Name (PRINT): _____

If seen as couple: Please complete a second Registration Form. Thank you.