TIMOTHY A. MURPHY, M.D.
PATIENT FORMATION
DEPENDENT

Date: ________________

Cell: ____
(area code)
Home: ____
(area code)
Work: ____
(area code)
Preferred Contact #: Cell Home Work

Name: ____ Date of Birth: ________________________
(Last) (First) (Initial)
Address: ____

City: ____ State: ________ Zip: ____________

Sex: M: ______ F: ______ Age: ________ Patient's Social Security #: ____

School: ____ Grade: ________________

Parent/Guardian with whom child is living: (1) ____ Phone: ________________

Relationship to patient: ____

Parent/Guardian with whom child is living: (2) ____ Phone: ________________

Relationship to patient: ____

Primary Care Physician: ____ Patient Referred By: ______________________________

In case of emergency, who should be notified? ____ Phone: ________________

INFORMATION ON PARENTS

Name of Legal Mother: ____ Phone: ____________________

Address (if different from patient): ____

Name of Legal Father: ____ Phone: ____________________

Address (if different from patient): ____

PRIMARY INSURANCE

Primary Insurance Company: ____ Phone: ________________

Primary Insured Person's Name: ____ Date of Birth: ____________________

Social Security #: ____ ID #: ________________________________ Group #: ________________

Insured Person's Address (if different from patient): ____

Insured Person's Phone: ____ Relationship to Patient: ______________________________

Insured Person's Employer: ____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes: _________ No: ___________ If yes, please turn over and complete the back of this form.

ASSIGNMENT, RELEASE, AND CONSENT TO TREAT

I AUTHORIZE Dr. Murphy to assess my condition and prescribe a treatment program. I also authorize the release of information to my primary care physician, the referring professional, and to any insurer for the purpose of remuneration to Dr. Murphy. I hereby assign directly to Dr. Murphy the payment of all insurance benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance.

____ ______________________________ ____________________
Signature Relationship Date