LINDA FOLTZ, PH.D.

LICENSED PSYCHOLOGIST

101 Devant Street, Suite 901
Fayetteville, GA 30214

Phone: 770/461-2520
Email:dr_lindafoltz@att.net

PATIENT/INSURANCE INFORMATION

SECTION I: Patient Information

Patient's Name: ______________________________

Patient's Date of Birth: ______________ Patient's SS#: ______________

Patient's Address: ______________________________

____

Home telephone: __________ Work Telephone: __________ ext ____ Cell Phone: __________

Patient's Relationship to Insured: ______________________________

Patient's Status (circle one each):

a. Single Married Other
b. Employed Full-Time Student Part-Time Student

Patient's Condition Related to:
a. Employment? Yes No
b. Auto Accident? Yes No (If yes, in what state?) __________
c. Other Accident? Yes No

SECTION II: Primary Insurance Information

Insured's Name: ______________________________

Insured's Date of Birth: ______________ Insured's ID# or SS# ______________

Insured's Address: ______________________________

____

Insured's Insurance Plan Name: ______________________________

Insurance Company Phone #: ______________ Policy or Group #: ______________

Insured's Employer's Name: ______________________________

Is there another health benefit plan? Yes No

IF YES, COMPLETE SECTION III

SECTION III: Secondary Insurance Information

(We do not file secondary insurance because of excessive delays in payment by secondary insurance companies unless it is required by the insurance company, but we are required by law to have this information on file.)

Insured's Name: ______________________________

Insured's Date of Birth: ______________ Insured's ID# or SS# ______________

Insured's Address: ______________________________

____

Insured's Insurance Plan Name: ______________________________

Insurance Company Phone #: ______________ Policy or Group #: ______________

Insured's Employer's Name: ______________________________

Is there another health benefit plan? Yes No