JAMIE WINDERBAUM FERNANDEZ, MD, PA

INTERVENTIONAL PSYCHIATRY OF TAMPA BAY

Patient Intake Form

Date: _____

Demographic Information:

First Name: _____
Middle Initial: _____
Last Name: _____
Date of Birth: _____
Social Security Number (Optional): _____
Sex: M __ F__ NB__
Marital Status: _____
Address: _____
City: _____
State: _____
Zip Code: _____
Phone Number: _____
Email Address: _____
Referring Physician Name (Optional): _____
Referring Physician Phone Number & NPI (Optional) : _____

Insurance Information:

Primary Insurance Company: _____
Subscriber ID # (including letters): _____
Group Number: _____
Secondary Insurance Company: _____
Subscriber ID # (including letters): _____
Group Number: _____
Insurance Policyholder Full Name: _____
Insurance Policyholder Date of Birth: _____
Insurance Policyholder Address: _____
Insurance Policyholder Relationship: Self __ Spouse__ Child __ Other __
Insurance Policyholder Social Security Number: _____
Insurance Policyholder Sex: M __ F __

Patient Authorization

I authorize the release of any medical and insurance information necessary to process any claim.

Patient Signature: _____ Date: _____

Patient Full Name: _____

Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician, if a referral is required by my insurance plan. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature: _____ Date: _____

Patient Full Name: _____

** Note: All signatures are required.*

Please call 813-251-1800 or email us at info@interventionalpsychiatrytb.com with questions. Fax the completed form to 813-251-9422 or email jwf@interventionalpsychiatrytb.com.