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 at Birth:	Identified Gender:	
Marital Status:		
Address:		
City:	State:	Zip code:
Phone Number:	Email Address:	
Referring Physician Name:	Referring Physician Number:	

INSURANCE INFORMATION

Primary Insurance Company:			
Subscriber ID # (including letters):	Group Number:		
Secondary Insurance Company:			
Subscriber ID # (including letters):	Group Number:		
Policyholder Full Name: FIRST MIDDLE LAST			
Policyholder Date of Birth: MM/DD/YYYY			
Policyholder Address:	City:	State:	Zip code:
Policyholder Social Security #:	Policyholder Sex: M ____ F_____ Other _____		
Policyholder Relationship to Patient: Self ____ Spouse ____ Child ____ Other: ____			

PATIENT AUTHORIZATION

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

Patient Signature: _____ Date: _____
(All signatures are required)

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: _____
(All signatures are required)

Patient Full Name: _____

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.