Wellman Psychology & Associates S.C.

3660 N. Lake Shore Drive, Suite 201
Chicago, IL 60613
(773) 683-1731
Fax (773) 435-6354

PATIENT INFORMATION

Name (First, MI, Last): ______________________________

Address (Street): ______________________________

City, State, ZIP: ______________________________

Home Phone: ______________ Work Phone: ______________

Birthdate: ______________ SS Number: ______________

Sex: Male Female Marital Status: Single Married Divorced Widow

Employer: ______________________ ______________

Employer Address: ______________________ Phone: ______________

School Name: ______________________________

Referral: ______________________________

RESPONSIBLE PARTY OR SPOUSE INFORMATION (Do not complete if you are the responsible party.)

Name (First, MI, Last): ______________________________

Relationship: ______________________________

Address (Street): ______________________________

City, State, Zip: ______________________________

Home Phone: ______________ Work Phone: ______________

Birthdate: ______________ SS Number: ______________

Employer: ______________________________

Employer Address: ______________________ Phone: ______________

Friend or Relative Not Living With You: ______________________________

PRIMARY INSURANCE INFORMATION (Do not complete if current insurance card on file.)

Insurance: ______________ Phone Number: ______________

Address (Street): ______________________________

City, State, ZIP: ______________________________

Insured's Name: ______________ Relationship: ______________

Member ID: ______________ Group ID: ______________

I hereby assign, transfer, and set over to Dr. James D. Wellman all of my rights, title, and interest to my medical/behavioral health reimbursement benefits under my insurance policy. I authorize release of any medical information needed determine these benefits. This authorization shall remain valid until written notice is given by me revoking authorization. I understand I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature: ______________________ Date: ______________