Richard A. Wyckoff, PhD

Patient Registration

Patient Information

Name: _____ SSN: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Sex: [ ] M [ ] F DOB: _____ Email: _____

Marital Status: [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Single [ ] Partnered for ___ years

Highest education attained: _____ Occupation: _____

Employer: _____ Work Phone: _____

Who referred you? / How did you know about us? _____

Physician Name: _____ Phone: _____

Person Responsible for Account

Name: _____ SSN: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Primary Insurance

Insurer Name: _____

Subscriber No.: _____ Group No.: _____

Secondary Insurance

Insurer Name: _____

Subscriber No.: _____ Group No.: _____

Assignment and Release

I certify that I have insurance coverage with the above named insurance company(ies). I hereby assign directly to Dr. Richard A. Wyckoff all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Richard A. Wyckoff may use my health care information and may disclose that information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining my insurance benefits. This consent will end when my treatment plan is completed and all benefits payable have been received.

I would like to learn about nutritional alternatives to psycho-active medications. [ ] Yes [ ] No

I authorize Dr. Wyckoff and any of my health care providers to collaborate and share information regarding my care.
[ ] Yes [ ] No

_____ _____ _____

Signature of patient Printed name Date

_____ _____ _____

Signature of parent, guardian or representative Printed name Date