EMPATHIC RESONANCE, LLC

EMPATHY DRIVEN INDIVIDUALIZED & HOLISTIC CARE ©

ADULT, CHILD & ADOLESCENT PSYCHIATRIC CONSULTATIONS & SERVICES

939 W North Ave STE 750, Chicago, IL, 60642 | +1 (312) 646-2112 |
firas@empathic-resonance.org

General Registration Form

Patient's Name: ____
Date of Birth: ________________________Marital Status: _____________
Age: ____ Sex: ______________
Street Address: ____
City, State & Zip code: ______________________________________
Social Security Number: ______________________________________
Cell Phone: ____
e-mail: ____

Employer's Name or School's Name: ______________________________
Primary Care Physician Name: _________________________________
Primary Care Physician Number: ________________________________
Therapist's Name: ____
Therapist's Number: _______________________________________

Father's Name: ____
Mother's Name: ____

Who is the Legal Guardian (if patient is a minor?) __________________

Today's Date: ____
Signature: ____

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Insurance Registration Form

Insured's Name: ____
Insured's Date of Birth: ______________________________________
Insured's Relationship to Patient: _______________________________
Street Address: ____
City, State & Zip code: _______________________________________
Social Security Number: ______________________________________
Cell Phone: ____
e-mail: ____

Insurance Plan or Program Name: ______________________________
Insurance Policy Number: ____________________________________
Insurance Group Number: ____________________________________

I hereby authorize the release of information including diagnosis, records, examinations and lab results to the above insurance company for the purpose of billing and claim submission.

Today's Date: ____
Signature: ____