

Frank Lucchetti , Ed.D
181 Andrieux Street, Ste. #204 Sonoma, CA 95476
Phone: 707-938-1030 Fax: 707-938-1900

Thank you for choosing our office.

In order to serve you properly we will need the following information. (PLEASE PRINT) All information will be strictly confidential.

Patient's name		Home Phone	Birthdate / /	Marital status
Residence address		City	State	Zip code
If patient is a child, parent or guardian's name				
Social security number			Driver's license number	
Name of employer/ occupation		Business address		Business phone
Do you have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, how do you intend to pay? <input type="checkbox"/> check <input type="checkbox"/> cash Credit card - <input type="checkbox"/> Visa <input type="checkbox"/> MC #		
Insurance company name and address *				
Subscriber name		Policy no.	Is this through your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of spouse		Birthdate / /	Social security number	
Name and address of spouse's employer			Business phone	
Is there secondary insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance company name and address			
Policy no.	Medicaid no.		Medicare no.	
Worker's Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of company			
Company phone	Treatment authorized by			
Person financially responsible for this account: <input type="checkbox"/> Self <input type="checkbox"/> Other: _____		Address		
Nearest friend or relative not residing with you		Relationship to patient	Phone	
If patient is child, who may authorize treatment for child?		Relationship to child	Phone	
Whom should we thank for referring you?		Address		
Do you authorize release of your medical information to anyone besides your insurance carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No			If so, whom?	
Do you have a telephone answering machine in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No. If so, may we leave messages from this office on that machine? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<i>* I authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.</i>				
_____				_____
Patient, Parent or Guardian Signature				Today's Date