LOURDES ORTIZ, LCSW-R

1560 Pelham Parkway South, #1Q, Bronx, NY 10461
80 East 11th Street, #212, New York, NY 10003 **Tel#: (212) 252-2745**

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Work Telephone: _____ Home Telephone: _____ Cell Phone: _____
E-mail address: _____

Sex: ___ male ____ female Subscriber social security #: _____
Marital Status: ____ married ____single ____ separated ____ widowed ____ divorced _____

Employer: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Address: _____
Tel#: _____

MEDICAL INFORMATION

Relevant medical conditions (history, current condition, changes in condition):
_____
_____

Medications (dosage, dates of initial prescriptions, name of prescribing professional):
_____
_____

Primary Care Physician Name: _____
Address: _____
Tel #: _____
Date of last physical exam: _____
Psychiatrist Name (if applicable): _____
Address: _____ Tel#: _____

INSURANCE INFORMATION

Name of Primary Insured: (if different from patient) _____

Relationship to patient: _____ DOB: _____ SS #: _____

Name of Insurance Company: _____ ID#: _____
Group #: (usually found on the front of the card) _____

Insurance Telephone #: (located on back of the insurance card) _____

Pre-certification #: _____

Co-payment amount: _____

INSURANCE AUTHORIZATION

I authorize payment of my insurance benefits for psychotherapy services to Lourdes Ortiz, LCSW-R. I understand that I am financially responsible for all charges whether or not paid by insurance.

Print Name: _____

Signature: _____ **Date:** _____