Alexey Tolchinsky, Psy.D.

11303 Amherst Ave., Suite 1, Silver Spring, MD 20902
847-E Quince Orchard Blvd., Gaithersburg, MD 20878
301-919-9259

PATIENT INFORMATION

Name:_____

Address:_____

City: _____State:_____ Zip:_____

Home Phone:_____ Work:_____Ext:_____

Cell Phone:_____Pager #:_____

Date of Birth:_____ Social Security #:_____

Marital Status:_____ Gender: Male Female

Employer or School:_____

Employment Status:_____

Referred by:_____

MEDICAL HISTORY

Current Medical History

Date of onset of current symptoms:_____

Currently under doctor's care: YES NO

Name of doctor(s) involved in your care

Primary Care Physician:_____

Address:_____

Phone #:_____ Fax #: _____

Being treated for:_____

_____

Psychiatrist:_____

Address:_____

Phone #:_____ Fax #: _____

Being treated for:_____

_____

Other Physicians:_____

Address:_____

Phone #:_____ Fax #: _____

Being treated for (including allergies):_____

_____

_____

Medications: NO YES If yes, please list below

Medication(s)	Dosage	Prescribing physician	Prescribed for
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

<u>Previous Medical History</u>

Previous psychotherapy or chemical dependency services: NO YES If yes, please list below

Date(s)	Facility/Therapist	Reason(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Hospitalizations: Medical, Psychiatric, Chemical Dependency: NO YES If yes, please list below

Date(s)	Reason(s)	Hospital/facility
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Insured Individual's Information

Patient's Relationship to Insured: Self Spouse Child Other

If "Patient's Relationship to Insured" is other than "Self," please complete the following. If patient is the insured individual, go directly to "Insurance Policy Information"

Insured's name:_____

Address:_____

City:: _____ State:_____ Zip:_____

Phone Nos: Home:_____Work:_____ Cell: _____

Date of Birth:_____ Social Security #:_____

Marital Status:_____ Gender: Male Female

Employer or School:_____Employment Status:_____

Insurance Policy Information

Insurance Company:_____

Address:_____

City:_____ State:_____ Zip:_____

Plan Name:_____

Policy Number:_____ Group Number:_____

Is the patient covered by more than one insurance? YES NO

If Yes, please complete the section on "Secondary Insurance Policy Information" below

If No, please go directly to "Billing Information" section

Secondary Insurance Policy Information

Insurance Company:_____

Address:_____

City:_____ State:_____ Zip:_____

Plan
Name:_____Policy

Number:_____ Group Number:_____

Billing Information

Person responsible for charges for this patient: PATIENT OTHER

If "Patient" – Please sign the Authorization section below

If "Other" – Please complete the following information below:

Name:_____

Address:_____

City:: _____ State:_____ Zip:_____

Phone Nos: Home:_____Work:_____ Cell: _____

Date of Birth:_____ Social Security #:_____

Marital Status:_____ Gender: Male Female

Employer or School:_____

Employment Status:_____

NOTE: Notice of Privacy Practices can be obtained from Dr. Tolchinsky upon request.

Authorization for Release of Medical Information and Assignment of Benefits

I am the patient or a person responsible for the patient. I accept responsibility for full payment for any services rendered by Alexey Tolchinsky, Psy.D. If there is an agreement between Dr. Tolchinsky and myself for his office to submit claims to my insurance company for payment, I authorize the release of medical or other information to my insurance company and/or other entities to assist in our billing and collection efforts. I understand that I am financially responsible for any balance not covered by my insurance carrier. I hereby assign insurance benefits otherwise payable to me, to Alexey Tolchinsky, Psy.D. I permit a copy of this authorization to be used in place of the original. I have read and understood this agreement.

Signature:_____ Date:_____