DAVID C. WADE, PSY. D., P.C.
1100 E. MARINA WAY, SUITE 221
HOOD RIVER, OR 97031 DX:_____

PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT: FIRST NAME: _____ MIDDLE INITIAL: ____ LAST NAME: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____ Mailing address if different: _____

SINGLE: _____ MARRIED: _____ PARTNERED: _____CHILD: _____ GENDER: M____ F___ Other ___

BIRTHDATE: _____ AGE: _____ REFERRED BY:_____

PARENTS (if minor client): _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____ PHONE NO:_____

Patient or parent:

HOME PHONE _____	MAY WE CALL? YES ☐ NO ☐	LEAVE A MESSAGE? YES ☐ NO ☐
WORK PHONE _____	MAY WE CALL? YES ☐ NO ☐	LEAVE A MESSAGE? YES ☐ NO ☐
CELL PHONE _____	MAY WE CALL? YES ☐ NO ☐	LEAVE A MESSAGE? YES ☐ NO ☐

Parent if patient is under 18.

HOME PHONE _____	MAY WE CALL? YES ☐ NO ☐	LEAVE A MESSAGE? YES ☐ NO ☐
WORK PHONE _____	MAY WE CALL? YES ☐ NO ☐	LEAVE A MESSAGE? YES ☐ NO ☐
CELL PHONE _____	MAY WE CALL? YES ☐ NO ☐	LEAVE A MESSAGE? YES ☐ NO ☐

INSURANCE INFORMATION NEEDS TO BE FILLED OUT ALONG WITH THE COPY OF YOUR CARDS

PRIMARY INSURANCE

SUBSCRIBER TO POLICY: _____ ID # :_____ GRP #:_____

DATE OF BIRTH: _____ ADDRESS IF DIFFERENT FROM ABOVE: _____

RELATIONSHIP TO PATIENT: SELF: _____ SPOUSE: _____ PARENT:_____ OTHER: _____

EMPLOYER NAME: _____

PRIMARY INSURANCE: _____

PRE AUTHORIZATION REQUIRED: YES: _____NO: _____

SECONDARY INSURANCE

SUBSCRIBER TO POLICY: _____ ID #: _____ GRP #:_____

DATE OF BIRTH: _____ ADDRESS IF DIFFERENT FROM ABOVE: _____

RELATIONSHIP TO PATIENT: SELF: _____ SPOUSE: _____ PARENT: _____ OTHER: _____

EMPLOYER NAME: _____

SECONDARY INSURANCE: _____

PRE AUTHORIZATION REQUIRED: YES:_____ NO: _____

DAVID C. WADE, PSY D. has my permission to bill my insurance(s) and use electronic billing.
I authorize him/ his office to release any information necessary to my insurance company to process my claims.
I further authorize that my insurance benefits be paid directly to DAVID C. WADE, PSY. D.
I understand I am fully responsible for all professional fees not covered by this assignment of insurance benefits.
I understand that payment in full is due at the time for service not covered by my insurance.

SIGNATURE _____ _ DATE _____