Dayspring Psychological Services
13-15 East Deer Park Drive, Suite 103D
Gaithersburg, MD 20877
(240) 686-6885

PATIENT CONTACT INFORMATION AND INSURANCE FORM

First Name:_____Middle Name: _____ Last Name:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Voice Message okay? Yes No

Work:_____ Voice Message okay? Yes No

Cell Phone:_____ Voice Message okay? Yes No Text okay? Yes No

Email address: _____

Date of Birth:_____ Age:_____ Gender: _____

How did you hear about Dr. Gordon?_____

EMERGENCY CONTACT INFORMATION

In case of emergency, who should I contact?_____

Home #:_____ Work #:_____ Cell #:_____

Is it okay to leave a voice message? Yes No Text message? Yes No

Contact person's relationship to patient:_____

By providing your signature below, you are giving Dr. Gordon permission to contact the person listed above in case of emergencies: _____ _____

(Signature of Client/Parent if Minor) (Date)

INSURANCE INFORMATION

(Please bring your insurance card so a copy can be made!)

Primary Insurance:

Name of Policy Holder (if different from patient): _____

Address of Policy Holder: _____

Work phone number:_____ Home: _____ Cell: _____

Occupation: _____ Date of birth: _____

Employer Name: _____

Employer Address: _____

Insurance Name: _____

Policy Number: _____

Address: _____

Phone Number: _____

Secondary Insurance (If applicable):

Name of Policy Holder (if different from patient): _____

Address of Policy Holder: _____

Work phone number:_____ Home: _____ Cell: _____

Occupation: _____ Date of birth: _____

Employer Name: _____

Employer Address: _____

Insurance Name: _____

Policy Number: _____

Address: _____

Phone Number: _____

PAYMENTS

You are responsible for your co-pays. Dr. Gordon will take a payment at each session unless a special arrangement has been made. Credit card payments are accepted, but cash or checks are preferred.