PSYCHOTHERAPY, PSYCHOANALYSIS
& GENERAL ADULT PSYCHIATRY

555 S. Old Woodward, Suite 602
Birmingham, Michigan 48009

phone: 248.594.6330
fax: 248.594.7465
email: senickolof@aol.com
www.drnickoloff.com

STEVEN E. **Nickoloff**, M.D.

NEW PATIENT REGISTRATION

Patient's Full Name: _____

Address: _____ **Date of Birth:** _____

City: _____ **Zip:** _____ **Social Security #:** _____

Home Phone: _____ **Sex:** ☐ **M** ☐ **F** **Marital Status:** _____

Cell Phone: _____ **Email:** _____

Full Name Referral Source: _____

RESPONSBILE PARTY (if other than patient) Name _____

Address _____ **City** _____

Zip Code _____ **Phone (home)** _____ **(cell)** _____

HEALTH INSURANCE INFORMATION

Primary Health Insurance Company: _____

Subscriber's Name: _____ **Date of Birth:** _____

Patient's relationship to insured: **Self** **Spouse** **Child** **Other**

Contract / Policy #: _____ Group #: _____

Employer: _____

Secondary Health Insurance Company: _____

Subscriber's Name: _____ **Date of Birth:** _____

Patient's relationship to insured: **Self** **Spouse** **Child** **Other**

Contract / Policy #: _____ Group #: _____

Employer: _____

CREDIT CARD INFO - if you wish to settle your account monthly using Visa/MC please complete:

Card Number: _____ Exp Date: _____

Name on Card: _____ 3 digit CVV code: _____

AUTHORIZATION & RELEASE

I hereby consent to treatment. I authorize the release of any information to billing agents and insurance carriers, as necessary in order to process claims and obtain reimbursement. This authorization shall remain valid until I give written notice revoking said authorization.

I understand that Dr. Nickoloff may not participate with certain insurances, and ultimately I am financially responsible for all charges.

Patient or Responsible Party's Signature _____