

CAROLJEAN BONGO, PSY.D., LLC

PATIENT REGISTRATION SHEET

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|---------------|--|--|
| Today's Date: | <input type="checkbox"/> 2909 Bent Ave, Cheyenne, WY 82001 | <input type="checkbox"/> 507 S. 4 th St., Laramie |
|---------------|--|--|

PATIENT INFORMATION

| | | | | | |
|-----------------|--------|---------|---|---|---|
| Last Name: | First: | Middle: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
| Street Address: | City: | State: | ZIP Code: | | |

| | | | | |
|---|---|-----------------------------|--------------------|---|
| Home phone no.: (space below) YES NO OK to leave message? () | Cell/Other contact no.: (space below) YES NO OK to leave message? () | Social Security no.: - - | Birth Date: / / | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
|---|---|-----------------------------|--------------------|---|

| | | |
|-----------|-------------|------------------------|
| Employer: | Occupation: | Work phone no.: () |
|-----------|-------------|------------------------|

| | | | |
|-----------------|-------|--------|-----------|
| Street Address: | City: | State: | ZIP Code: |
|-----------------|-------|--------|-----------|

E-mail address: _____

| | | |
|--|--------------------------------|---------------------|
| Notify Primary Care Physician? <input type="checkbox"/> YES <input type="checkbox"/> NO | Name of Primary Care Physician | Contact no.: () |
|--|--------------------------------|---------------------|

IN CASE OF EMERGENCY

| | | |
|-------------------------|------------------------|------------------------|
| Emergency Contact Name: | Home phone no.: () | Cell phone no.: () |
|-------------------------|------------------------|------------------------|

INSURANCE INFORMATION

| | | | | | |
|---------------------------------------|--------------------------------|----------------------|---|---|---|
| Insured's Last Name (if different): | First: | Middle: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
| Home phone no.: (if different) () | Cell/Other contact no.: () | Social Security no.: | Birth Date: / / | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | |

| | | |
|--------------------|----------------------------|-----------------------------|
| Insurance Company: | Insurance Billing Address: | Insurance phone no.: () |
| Employer: | () | |

| | | | | | |
|-------------|------------|--------------------------|-------------------------------|---------------------------------|------------------------------------|
| Policy no.: | Group no.: | Relationship to Insured: | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Dependent |
|-------------|------------|--------------------------|-------------------------------|---------------------------------|------------------------------------|

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

| | | | | | |
|--------------------|----------------------------|-----------------------------|-------------------------------|---------------------------------|------------------------------------|
| Insurance Company: | Insurance Billing Address: | Insurance phone no.: () | | | |
| Policy no.: | Group no.: | Relationship to Insured: | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Dependent |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Caroljean Bongo PsyD, LLC, those acting on the practice's behalf, and my insurance company to release any information required to process my claims.

Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

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| <hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> <i>Patient/Guardian signature</i> | <hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> <i>Date</i> |
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*** PLEASE NOTE: 24 HOUR CANCELLATION POLICY – Please be advised that 24 hours notice is required for cancellations. Otherwise, your account will be charged for the session amount. Thank you for your cooperation.**