Dr. Nancy Stechler
Clinical Psychologist

PATIENT INFORMATION

Name: _____ Date: _____

DOB:_____ EMAIL: _____

Address:_____

City/State/Zip:_____

SS#:_____

Home Phone:_____ Cell/Work Phone: _____

(Please indicate the preferred phone number to use for messages.)

Referred By:_____

Primary Care Doctor:_____ Phone:_____

Emergency Contact:_____ Phone: _____

INSURANCE INFORMATION

Subscriber Name: _____ Rel. to Patient: _____

Address: _____

City/State/Zip: _____

SS#:_____ DOB: _____

Home Phone:_____ Cell/work Phone:_____

Primary Insurance Co._____

SUBSCRIBER ID#:_____ Grp #: _____

Insurance Co. Phone#:_____ Co-pay Amount:_____

Deductible: Y or N If yes, has it been met? Y or N

Secondary Insurance _____

Subscriber ID#: _____ Grp #: _____