PATIENT REGISTRATION FORM
Zachary Sikora, Psy.D.
18-2 East Dundee Road, Suite 140, Barrington, IL 60010

Patient Name:____________________________________ Date of Birth: ________________ Sex: M/F
Billing Address:____________________________________ Marital Status: S M W D
____
E-mail Address:______________________________ Okay to send correspondence or statements?_____
If minor (under age 18) please write name of legal guardian:____
Social Security Number:____________________________
Home Phone: __________________________ Okay to call?_________
Work Phone:___________________________ Okay to call?_________
Cell Phone:____________________________ Okay to call?_________
Employer Name: ____
City:_____________________________________

Primary Insurance:

Insurance Carrier:____
Phone Number:____
Identification Number:_______________________________ Group Number:______________________________
Subscriber Name: ___________________________ Subscriber Date of Birth:_____________________________
Insurance Claims Mailing Address:____
____

Secondary Insurance:

Insurance Carrier:____
Phone Number:____
Identification Number:_____________________________ Group Number:__________________________________
Subscriber Name:_________________________________ Subscriber Date of Birth_________________________
Insurance Claims Mailing Address:____

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Please read the following carefully and sign below:

I give permission to Zach Sikora, PsyD, and billing staff to send required information to my insurance company or my EAP. I am aware that I am placing my signature on file. I also understand that any unpaid balance such as copays, deductibles, and non covered services I will be responsible for. I understand there may be a fee if I fail to give notice for cancellation of my appointment. I understand that my insurance or EAP does not cover the cost of missed sessions.

Signed:____

Date:_______________________________________