JEFFREY SIMON MD
ADDICTION MEDICINE & PSYCHIATRY
1930 Marlton Pike East, Suites U 99 & U 100 • Cherry Hill, NJ 08034
Phone: 856-888-1326 Fax: 856-281-9898

PATIENT'S PERSONAL INFORMATION

PATIENT'S NAME: _____

HOME ADDRESS: _____

CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ SS#: _____

HOME TELEPHONE: _____ BUSINESS TELEPHONE: _____
CELLULAR NUMBER: _____ WHICH NUMBER MAY WE CONTACT YOU? _____

EDUCATION: _____

MARITAL STATUS: _____ NAME OF SPOUSE: _____
SPOUSE'S DATE OF BIRTH: _____

NUMBER OF CHILDREN AND AGES: _____

_____

REFERRED BY: _____

HAVE YOU HAD MENTAL HEALTH TREATMENT BEORE? ☐ Yes ☐ No

WHERE HAVE YOU BEEN TREATED AND APPROIMATE DATES: _____

_____

NAME AND ADDRESS: _____

_____

IF THIS IS A MATTER FOR LEGAL INVOLEMENT, THIS MUST BE ARRANGED PRIOR TO YOUR APPOINTMENT.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDEDED. THANK YOU.

ACKNOWLEDGEMENT: THERE WILL BE A CHAREGE FOR ANY BROKEN APPOINTMENT IF NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE. I AM INFORMED THAT THE DOCTOR IS RESERVING A TIME FOR ME. I UNDERSTAND THAT I WILL BE PRESONALLY LIABLE FOR THOSE CHARGES. I ALSO UNDERSTAND THAT THE OFFICE RESERVES THE RIGHT TO RESCHEDULE MY APPOINTMENT IF I AM MORE THAN 15 MINUTES LATE.

I AM INFORMED THAT THE OFFICE DOES NOT ACCEPT ANY HEALTH INSURANCE NOR WILL THE OFFICE PROCESS ANY CLAIM. I PERSONALLY WILL BE LIABLE FOR THE PAYMENT FOR ANY SERVICE RENDERED.

_____ _____

SIGNATURE DATE