Steven J. Covelluzzi, Psy.D.
Clinical Psychologist
PSY 24668

2333 Camino del Rio South, Suite 160
San Diego, California 92108
T: 619-342-4155
F: 619-694-4840
www.sjcbehavioralhealth.com

Child / Adolescent / Adult / Patient Registration:

Today's Date:	Patient's First Name:	Middle Name:	Last Name:	Date of Birth:

Mailing Address:	City:	State:	Zip Code:

Home Phone:	Mobile Phone:	Best number to leave a message: Y / N

Patient's School / Grade	School Address	City	State:	Zip Code:

Name, ages, and relationship of additional individuals living with the patient:

_____ _____ _____

_____ _____ _____

Alternative Child / Adolescent Address:

	City:	State:	Zip Code:

Responsible Party for Bill: (of minor)

Legal Guardian's Name:	Mobile Number:	Age:	Date of Birth:	Relationship to Patient:

Billing Address:	City:	State:	Zip Code:

Guardian's Occupation:	Employer:	City:	State:	Zip Code:	Work Phone:

Primary Insurance Carrier: Secondary Insurance Carrier:

Company:	Phone Number:	Company:	Phone Number:

Address:	City:	State:	Zip Code	Address:	City:	State:	Zip Code:

Insured: (Name on card)	Policy# _____ Group#_____ Effective Date_____	Insured: (Name on card)	Policy# _____ Group#_____ Effective Date_____

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591 Camino de la Reina, Suite 1219
San Diego, California 92108
P:
F:
WWW.

If not using medical insurance and prefer private pay, who will be paying?

Name: Relationship to minor (if applicable)	Address:	Phone number:

Please understand that if you will be paying privately (out of pocket), fees are required at time of service(s).

Primary Care Physician:

Name:	Address:	Phone number:

Emergency Contact:

May this person be contacted in the event of an emergency: Yes No

Name:	Address:	Phone number(s):

Referral Source:

How did you hear of Dr. Covelluzzi's services?

May this person be contacted to coordinate care? Yes No

Name:	Address:	Phone number(s):

Authorization to pay benefits to provider: I hereby authorize payment direct to Steven J. Covelluzzi, Psy.D. of the insurance benefits otherwise payable to me, and authorize release of information necessary to process a claim with my insurance company. I hereby accept responsibility for any charges not covered by my insurance, and for missed appointments or cancelations less than twenty-four (24) hour notice. A copy of this signature is valid as the original.

Signature: _____ Date: _____
(If a minor, parent or legal guardian must sign