

**Bradley D. Powell, PhD**  
**2400 Broadmoor \* Suite C \* Bryan, TX 77802 \* Ph (979) 774-9255 \* Fax (979) 774-9299**

**PATIENT INFORMATION (please print clearly)**

Patient's Name	Marital Status S M W D Sep	Sex M F	Age	Date of Birth	Social Security #
Street Address	City and State	Zip Code	Home Phone #		
Patient's Employer (or school)	Occupation			Business Phone #	
Employer's Street Address	City and State	Zip Code	Other Phone #		
Emergency contact (not living with you)	Relationship			Phone #	
E-mail address:					
Who referred you to this practice?			Who is your Family physician/PCP?		

**IF THE PATIENT IS NOT THE INSURED:**

Responsible party's name	Marital Status S M W D Sep	Sex M F	Date of Birth	Social Security #
Street Address	City and State	Zip Code	Home Phone #	
Employer	Occupation			Business Phone #
Employer's Street Address	City and State	Zip Code	Relationship to patient	

**PRIMARY INSURANCE**

Name of insurance company	Phone # (to verify benefits)	Phone # (for precertification)
Street Address	City and State	Zip Code
ID#	Group #	Name of the insured
		Group Name (or employer name)

**SECONDARY INSURANCE**

Name of insurance company	Phone # (to verify benefits)	Phone # (for precertification)
Street Address	City and State	Zip Code
ID#	Group #	Name of the insured
		Group Name (or employer name)

**PHARMACY INFORMATION**

Name of Pharmacy	Pharmacy Address	Pharmacy Phone #
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**AUTHORIZAION TO RELEASE MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS:**

I hereby authorize Bradley D. Powell, Ph.D. to furnish appropriate and necessary details of medical and psychological information to my insurance company.  
 I hereby authorize payment of medical and psychological benefits to Bradley D. Powell, Ph.D. for services rendered.  
 I give my permission to Bradley D. Powell, Ph.D. to provide psychological services to the patient listed above.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

(if patient is a minor)