Jeffrey H. Simon, M.D.
800 Kings Highway North
Suite 506
CHERRY HILL, NJ 08034

PATIENT'S NAME:_____

HOME ADDRESS: _____

CITY, STATE, ZIP:_____

DATE OF BIRTH:_____ SS: _____

HOME TELEPHONE NUMBER:_____

BUSINESS TELEPHONE NUMBER:_____

CELLULAR NUMBER:_____

AT WHICH OF THE ABOVE NUMBERS 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 BEFORE?_____

WHERE HAVE YOU BEEN TREATED AND APPROXIMATE DATES:_____

_____

NAME AND ADDRESS:_____

_____

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

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

ACKNOWLEDGEMENT: THERE WILL BE A CHARGE 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 PERSONALLY 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