

**PATIENT INFORMATION FORM**

(Please Print)

**About the patient:**

Name \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Street Address \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

City, State \_\_\_\_\_ Zip code \_\_\_\_\_

Male  Female AGE \_\_\_\_\_

Marital status (check one)  Single  Married  Other

Employment/School status (check all that apply)  Employed  Full-time student  Part-time student  NA

Primary Care Physician Name (required to obtain authorization) \_\_\_\_\_

**Are visits related to:** Employment (*worker's compensation claim*)  Yes  No

Auto Accident  Yes  No Another Accident  Yes  No If yes, in what state? \_\_\_\_\_

**If patient is under 18, please complete this section:**

Statement of legal authority to authorize treatment for minor: *I declare that I am the custodial parent or legal guardian of the child described above and that I have the legal authority to request and consent to his/her psychological treatment.*

Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent/ Legal Guardian Name \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Street Address \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Male  Female

City, State \_\_\_\_\_ Zip code \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Contact numbers:**

Home phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Which one is preferred (check one):  Home  Cell  Work

**Non-Insurance/Other Payers (if applicable)** Check one:  Full Pay  EAP  Other

Eap/Other Company name: \_\_\_\_\_ Authorization # \_\_\_\_\_

Eap/Other Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

How many visits authorized: \_\_\_\_\_

**PRIMARY INSURANCE (if applicable)**

Name of Insurance Company \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policyholder's Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address (if different) \_\_\_\_\_

Male  Female

City, State \_\_\_\_\_ Zip code \_\_\_\_\_

Insurance ID # \_\_\_\_\_

Policyholder phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Group or Account # \_\_\_\_\_

Patient relationship to Policyholder: (check one)  Self  Spouse

Child  Other (specify) \_\_\_\_\_

Policyholder's Employer Name \_\_\_\_\_

Ins Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Is there a secondary insurance (check one)?  Yes  No

**SECONDARY INSURANCE (if applicable)**

Name of Insurance Company \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policyholder's Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address (if different) \_\_\_\_\_

Male  Female

City, State \_\_\_\_\_ Zip code \_\_\_\_\_

Insurance ID # \_\_\_\_\_

Policyholder phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Group or Account # \_\_\_\_\_

Patient relationship to Policyholder: (check one)  Self  Spouse

Child  Other (specify) \_\_\_\_\_

Policyholder's Employer Name \_\_\_\_\_

Ins Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_