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 (____)____-____