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PATIENT INFORMATION

Patient Name: ______________________ Today's Date: ______________________

Address: ______________________ Email: ______________________

City/ST/Zip: ______________________ GENDER: Male Female

Phone: (h) ______________________ Marital Status: Married Single Other

(w) ______________________ Student (age 19 - 23): Full-Time Part-Time

(c) ______________________ Employed: Yes Retired n/a

Date of Birth: ____________ Ethnic/Cultural Identity or Religious Affiliation if Desired: ______________________

Employee Assistance Program (EAP) APS, UBH etc: ______________________

AUTHORIZATION #______________________

INSURANCE INFORMATION

Primary Insurance Co.: ______________________ Plan Name: ______________________

Group Number: ______________________ Insured's Social Security #: ______________________

Name of Insured: ______________________ Insured's ID No.: ______________________

Insured's Address: ______________________ Insured's Date of Birth: ______________________

Employer: ______________________ Insured's Phone: ______________________

Patient's Relationship to Insured: Self Spouse Child/Stepchild Other____________

Secondary Insurance Co. ______________________ Plan Name: ______________________

Group Number: ______________________ Insured's ID No.: ______________________

Name of Insured: ______________________ Insured's Date of Birth: ______________________

Employer: ______________________ Insured's Phone: ______________________

Patient's Relationship to Insured: Self Spouse Child/Stepchild Other

Diagnostic Code:______________________Office use Only

RESPONSIBLE PARTY INFORMATION (if different from client)

Name: ______________________________ Phone: (h) ______________________

Address: ______________________________ (w) ______________________

______________________________ (c) ______________________

In the event that we need to reach you about scheduling or billing, may we:

Leave a voicemail?	Yes	No
Send an email?	Yes	No
Share scheduling or billing information with your spouse or parent ?	Yes	No

BACKGROUND

Education ____

Who suggested you contact me? ______________________Date symptoms/problems began__________

Briefly describe your reason for seeking help ______________________________

____

____

____

____

Primary Care Physician ______________________________Date of Last Exam ______________

Current Medications (if any) ____

____

Physical health problems or concerns ____

I understand that there is a 24-hour cancellation policy, and that appointments cancelled or missed without sufficient notice will be billed at full fee. Because missed appointments cannot be billed to insurance, I understand that I will be responsible for all charges for those appointments.

I hereby authorize my insurance benefits to be paid directly to the provider. I realize that I am responsible to pay for any non-covered services, and that I will be liable for a monthly finance charge of 1.0% on balances over 60 days past due. I hereby authorize the release of pertinent medical information to the insurance company.

Signed ______________________________ Date ______________________