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PATIENT INFORMATION

Patient Name:_____ Today's Date:_____

Address:_____Date of Birth: _____

City, ST/Zip:_____ Gender:_____Male _____Female

Email:_____ Marital Status:_____Married _____Single _____Other

Phone: (h) _____

(w)_____ Employed:_____yes _____retired _____n/a

(c) _____ Student (age 19-23): _____Full time _____Part Time

INSURANCE INFORMATION (Please provide a copy of your card.)

Primary Insurance Co. _____

Insured's ID No.:_____Group Number:_____

Name of Insured:_____Employer:_____

Insured's Address: _____ Insured's Date of Birth_____

_____Insured's Phone No._____

PATIENT'S RELATIONSHIP TO INSURED:

_____Self _____Spouse _____Child/Stepchild _____Other

Employee Assistance Program (EAP) Only _____APS _____UBH _____Other

AUTHORIZATION #_____

For Office Use Only

DX: _____

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 _____