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New Patient Information Sheet

Today's Date: _____ D.O.B. _____Age: _____

Name: _____ Soc. Sec. #_____

Address: _____
Street City & State Zip Code _____

Home Ph. # _____Business Ph. # _____ Cell Ph. #_____

Email address: _____

Marital Status: _____How Long? _____

Children (include age and sex) _____
_____
_____

Employer: _____How Long? _____

Occupation: _____

Whom may we thank for referring you to our office? _____

Briefly explain what problems bring you here _____
_____

Is your problem the result of an accident or illness? _____

If so, what is the date of occurrence? _____

OVER

Psychological and Medical History

Prior Mental Health Treatment (include dates) _____

_____

Significant Medical Illnesses or Surgeries (include dates) _____

_____

Are you currently taking any medications? If so, please list: _____

_____

Billing Information

Are you paying by (PLEASE CIRCLE): Insurance Check Cash Credit Card

Insurance company name: _____

Claims address: _____

Policy #_____Group # _____

Who is the policy's subscriber? _____

Subscriber's address: _____

Street City & State Zip Code

Subscriber's Phone # _____Sub's D.O.B. _____

Permission to release medical information/records

Permission is hereby granted for release of my psychological records to my referring physician(s) as needed for my treatment, and to my insurance carrier as needed for reimbursement.

Signature _____Date_____

(Patient or Guardian for Child)

If payment is by insurance, you are liable for amount not covered by your carrier. Thank You!