New Patient Information

DATE: _______________ PSYCHOLOGIST: ________________________________ DX: __________________

PATIENT'S NAME: ____ DOB: __________ AGE: _____

SEX: M F PARTNER STATUS: S M D W SEP

ADDRESS: _____________________________________ CITY: _________________ ST: ____ ZIP: __________

HOME PHONE: ( )____________________ WORK PHONE: ( )____________________ EXT:__________

CELL PHONE: ( )____________________ E-MAIL: ____

SS#: ______________________ EMPLOYER: ____

MAY WE CONTACT YOU AT YOUR PLACE OF EMPLOYMENT? Y N ; HOME? Y N

MAY WE MAIL CORRESPONDENCE TO YOUR HOME? Y N

EMERGENCY CONTACT PERSON: __________________________________ PHONE: ( )______________

****

WHO REFERRED YOU TO OUR OFFICE?: ____

****

PRIMARY INSURANCE CO.: ____ ID#: __________________

GROUP #: _____________ PLAN #: ______________ EMPLOYER: ___________________________________

WHO CARRIES PRIMARY INSURANCE?: SELF SPOUSE OTHER _____________________________

SS # OF INSURED: ______________________ DOB: _____________

2NDARY INSURANCE CO.: ____ ID#: __________________

GROUP #: _____________ PLAN #: ______________ EMPLOYER: ___________________________________

WHO CARRIES 2NDARY INSURANCE?: SELF SPOUSE OTHER ______________________________

SS # OF INSURED: ______________________ DOB: _____________

****

REASON FOR SEEKING PSYCHOTHERAPY: ____

____

It is very important for you to understand the benefits that your insurance company offers for outpatient mental health claims. Many times, the coverage differs from medical coverage. Our office will call to verify benefits, however, it is the insured's responsibility to understand the benefits offered.

____ __________________

PATIENT SIGNATURE DATE

1/1/2010