PATIENT INFORMATION

Date::_____ Counselor:_____ DSM-IV:_____

REFERRAL: Who referred you to this office?_____
Physician____Friend_____School____Other_____

PATIENT:
First Name:_____M.I._____ Last Name:_____

Address:_____,_____City:_____State_____Zip_____

SS# Number:_____-_____-_____ Birth Date:_____/_____/_____ Age:_____ Sex: ___M___F

Phone: Home_____ Work:_____ Cell:_____

E-mail Address: (Optional)_____

Single___Married___Divorced___Employed____ Employer:_____

If patient is a student: _____ _____
Name of school Grade
If patient is a minor, are parents divorced?_____Yes____No "Joint Custody"? _____Yes ____No
If parents are divorced, who has sole custody? _____

RESPONSIBLE PARTY TO BILL:
Check whichever applies: ( ) Self-Pay ( ) File Insurance

First Name: _____ Last Name:_____

Address: _____City:_____State:_____Zip:_____

Phone : Home:_____Work:_____ Cell:_____ Employer:_____

Relationship to patient: _____, self _____spouse_____parent_____other(explain)

PERMISSION TO SPEAK TO OTHERS FOR APPOINTMENTS OR IN AN EMERGENCY

Please list person(s) with whom we can speak regarding scheduling and who we can contact in case of an emergency:

1._____
Contact Person Relationship to Patient Phone Number

2._____
Contact Person Relationship to Patient Phone Number

May we leave messages on an answering machine or cell phone regarding appointments? ( ) Yes ( ) No

I give my permission for this office to speak to the person(s) listed above regarding scheduling or in case of an emergency. _____(Patient Initials)

If we are contracted providers with your insurance and you do not want us to file your insurance, please check here: ____do not file (you will be asked to sign a waiver acknowledging this decision).

If we will file insurance on your behalf, please complete the information below.

INSURANCE:

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
_____ Name of Insurance	_____ Name of Insurance
_____ Insured's Name (Last, first, MI)	_____ Insured's Name (Last, first, MI)
_____/____/_____ Insured's Date of Birth	_____/____/_____ Insured's Date of Birth
_____ Insured's ID Number	_____ Insured's ID Number
_____ Insured's Group Number	_____ Insured's Group Number
_____ Insured's Employer	_____ Insured's Employer
_____ Insured's Work Telephone #	_____ Insured's Work Telephone #

FAMILY DATA	**NAME**	**AGE**	**BIRTH DATE**	**LIVING?**
Mother				
Father				
Spouse				
Brothers/Sisters				
Children				

Name of nearest relative : _____ _____ _____
(not at your present address) Name Relationship Phone

FAMILY PHYSICIAN:_____ **PEDIATRICIAN:**_____

Are you in good health? Yes____ No___ Explain:_____

_____

Are you currently under medical treatment? Yes____No____

With whom?_____ For what condition?_____

What medications are you currently taking?_____

_____

Have you ever had previous psychological treatment? Yes___No____ List dates, counselor, hospital:

_____