

NEW PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Gender: M / F / Other
Address: _____
City: _____ State: _____ Zip: _____
Preferred Contact Number: _____ Other: _____ Ok to leave a voicemail? Y / N
Ok to text appointment reminders? Y / N Preferred Number to text: _____
Email: _____ Would you like to receive secure emailed appointment reminders? Y / N
Emergency Contact: _____ Phone: _____ Relationship to patient: _____
Who referred you to my office: _____
Please list the main reasons for seeking psychological services: _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE SECTION BELOW:

Legal Guardian Name(s): _____ Relationship to child: _____
Legal Guardian Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Preferred Contact Number: _____ Other: _____ Ok to leave a voicemail? Y / N
Ok to Text Appointment Reminders? Y / N

If parents are separated or divorced, OR you are not the parent, please provide the name of the other parent/guardian(s) not listed above and their contact information:

Name: _____ Relationship to child: _____
Address: _____ City: _____ State: _____ Zip: _____
Preferred Contact Number: _____ Other: _____ Ok to leave a voicemail? Y / N

BILLING INFORMATION:

Person responsible for the Bill: _____
Address: _____ City: _____ State: _____ Zip: _____
Preferred Contact Number: _____ Other: _____ Ok to leave a voicemail? Y / N

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Phone Number: _____
Insurance ID#: _____ Group #: _____
Policy Holder's Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____

PLEASE COMPLETE SECTION BELOW FOR ANY *SECONDARY* INSURANCE

Insurance Company: _____ Phone Number: _____
Insurance ID#: _____ Group #: _____
Policy Holder's Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____