Patient's Name: _____Patient's Birthdate:_____
(Last Name, First Name, Middle Initial) Male_____ Female _____

Patient's Address: _____
(Number, Street Name, City, State, Zip Code)
Patient's Home Phone #:_____Cell #:_____Work #:_____

Emergency Contact:_____
(Name, relationship, phone numbers, address)
Patient Relationship to Insured: Self Spouse Child Patient's Status: Single Married Other
(please circle) (please circle)
Insured's Name:_____Insured's Birthdate:_____
(Last Name, First Name, Middle Initial) Male_____Female_____

Insured's Address:_____
(Number & Street Name, City, State, Zip Code)

Insured's Home Phone:_____ Cell Phone:_____

Insurance Plan Name:_____Insured's ID#:_____

Insured's Employer's Name/School Name:_____Work Phone #:_____

Other Health Insurance Plan Name:
Insured: Date of Birth:
ID#: Insured's Address:

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to my psychologist for services provided.

_____ _____
(Signature) (Date)

My signature below indicates that I have read the Psychologist/Patient Agreement and agree to its terms and also serves as an acknowledgement that I have received the HIPAA notice described in the Agreement.

_____ _____
(Signature) (Date)

Health Problems and Medications:_____

Previous Therapy/Psychological Assessment:_____

Primary Care
Physician:_____Phone/Address:_____

Others Living in Household:

Name	Relation	Date of Birth	School/Work	Grade/Work Phone
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____