Abintra Psychological Associates, LLC
175 Pine Street
Buffalo, WY 82834
307-684-5828 / Fax: 307-684-5803

Patient Information

Name: _____ Social Security Number: _____

Birth Date: _____ Gender: _____ Marital Status: _____

Home Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Work Address: _____

Name of Parents/Guardians (if patient is a minor): _____

Medical Information

**Primary Care Physician: _____ Phone: _____

Address: _____

Current Medications (include prescriptions, over-the-counter, and herbal preparations):

_____

_____

_____

**In the event of any medical emergency occurring at the Abintra office, this physician will be contacted.

Emergency Contact Information

Name of contact: _____

Relationship to Patient: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Work Address: _____

_____ (initial) I give permission to Abintra Psychological Associates to contact the above named individuals in case of an emergency.

Insurance Information

Primary Insurance Company: _____

Address: _____ Phone: _____

Name of Insured Person: _____ Birth Date: _____

Social Security Number: _____ Relationship to Patient: _____

Employer Name and Address: _____

_____

Group #: _____ ID #: _____

Secondary Insurance Company: _____

Address: _____ Phone: _____

Name of Insured Person: _____ Birth Date: _____

Social Security Number: _____ Relationship to Patient: _____

Employer Name and Address: _____

_____

Group #: _____ ID #: _____

_____ (initial) I authorize the release of information necessary to process insurance claims.

_____ (initial) I authorize the direct payment of benefits to Abintra Psychological Associates. If payment is made directly to me, I hereby agree to promptly remit such payment to Abintra. I understand that I will be responsible for any services not covered by insurance.

_____ _____

Signature of Patient/Parent/Guardian Date