Patient Information Sheet

General Information **Date:__________**

Last Name ___________________ First __________________ Middle ________________Birthdate ______/______/______

Address ______________________________________ City _____________________ State _________ Zip __________

Sex ______M ______F Marital Status ________ Social Security # _______ - _______ - _______

Employer _______________________ Relation to Insured _________________ Referred by ____________________

Emergency Contact: Name ________________________ Relationship ________________ Phone # _______________

Phone: Home # (___) _____-_______ May we leave a message? YES NO E-Mail Address_________________________

Cell# (___) _____-_______ May we leave a message? YES NO Work #(___) _____-_______ May we leave a message? YES NO

Insurance Information- Primary Insurance **Authorization Number:________________________**

Insured Last Name____________________ First _________________ Middle ________________Birthdate ____/____/____

Address _____________________________________ City _____________________ State _________ Zip _________

Telephone (___)____-_________ Sex ____M ____F Marital Status ________ Social Security # ______-______-______

Employer _____________________ Insurance Company ____

Address ____________________________________ City ____________________ State ________ Zip ___________

Insurance Phone # (__)____-_______Policy/Subscriber Number __________________________ Group Number ________________

Insurance Information – Secondary Insurance

Insured Last Name____________________ First _________________ Middle ________________Birthdate ____/____/____

Address _____________________________________ City _____________________ State _________ Zip _________

Telephone (___)____-_________ Sex ____M ____F Marital Status ________ Social Security # ______-______-______

Employer _____________________ Insurance Company ____

Address ____________________________________ City ____________________ State ________ Zip ___________

Insurance Phone # (__)____-_______Policy/Subscriber Number __________________________ Group Number ________________

Coordination of Care

It is important for your health care providers to speak to each other, so we may work together to help you. Please complete the information below and indicate your approval for us to coordinate care.

Primary Care Physician:_____________________________________Phone:________________ Fax:__________________

Address:____ City:_________________ State:__________Zip:___________

May we contact your physician____Yes ____No _______ I do not have a physician

Psychiatrist:________________________________Phone:________________ Fax:__________________

Address:____ City:_________________ State:__________Zip:___________

May we contact your psychiatrist _____Yes ______No ____ I do not have a psychiatrist

Assignment & Release: I herby assign my insurance benefits to be paid directly to the undersigned therapist. I am financially responsible for non-covered services. I also authorize the therapist to release any information requested.

____ ___________________

Client Signature or Authorized Parent/Guardian **Date**