PATIENT INFORMATION FORM

Name _____Date of Birth ____/____/____

Age _____ Relationship Status _____ Soc. Sec. Number _____

Home address_____
Street # City State Zip

Please list your phone numbers and check next to the number(s) where you prefer to be contacted:
☐ Home phone (____)_____ Message may be left at this number: Yes ☐ No ☐
☐ Work phone (____)_____ Message may be left at this number: Yes ☐ No ☐
☐ Cell phone (____)_____ Message may be left at this number: Yes ☐ No ☐

Email Address: _____

Insurance Coverage

Primary Ins. Type:_____Group#: _____ ID#: _____

Name of Insured: _____ Relationship to Patient: _____

DOB (of insured): _____ SS# (of insured): _____

Address (of insured): _____City_____State_____ Zip:_____

Employer through which you have this coverage:_____

Emergency Contact:
(Due to Confidentiality Policy this person will only be contact in the event of an emergency)

Name_____ Relationship_____
Phone number_____

Have you previously been seen for mental health treatment? Yes ☐ No ☐

If yes, please list the provider(s), treatment(s), duration(s):

_____

_____

Are you currently taking medication? Yes ☐ No ☐. If Yes, please list.

_____

How were you referred to my practice? _____

_____ _____/_____/_____
SIGNATURE DATE

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