CONFIDENTIAL
NEW PATIENT INFORMATION

Name_____________________ Date of Birth ___________Today's Date____________

Please Check: Female □ Male □ Age: ___ Social Security #:_____-____-_______

Home Address____________________________________

City________________ State______ Zip__________

Telephone (Home)___________________ Telephone (Cell)___________________

Email________________________________

Employer (or School): ____

Occupation __________________________

Work Address____________________________________

City________________ State______ Zip_______Phone (Work) ________________

Person Responsible for Payment____________________

Insured Name___________________

Insured Social Security # _______-_____-________

Relationship to Insured □ Self □ Spouse □ Child □ Other________________

Insurance Company/Plan______________________________________

Insurance ID Number_____________________________________

Insurance Group Number__________________________________

Insurance Address_______________________________________

City________________ State______ Zip__________

Telephone (Insurance Company)____________________________

Do you need pre-authorization for this service: __________

Emergency Contact Name_______________________ Relationship_______________

Telephone (Emergency Contact)____________________

Nature of Assistance you are seeking: (Please check)

Psychotherapy/Counseling □ Psychological Testing □ Other □ ________________

How did you hear about this service? _______________________________________