

**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) \_\_\_\_\_

Employer (or School): \_\_\_\_\_

Occupation \_\_\_\_\_

Work Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (Work) \_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_

Insured Name \_\_\_\_\_

Insured Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to Insured  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Plan \_\_\_\_\_

Insurance ID 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? \_\_\_\_\_