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PATIENT INFORMATION

Date: _____

Patient's Last Name _____First _____MI _____

SSN:_____ DOB_____

Age_____ Gender: M F

Address_____

City_____ State _____Zip_____

Home Phone # _____Cell Phone #_____

Parents/Guardians:

_____ N/A

Name of Primary Insurance: _____

Group #_____ ID #: _____

Subscriber _____ DOB:_____

Subscriber's Employer_____

Authorization for Mental Health Benefits required? Y N

If yes, authorization number:_____

Primary Care Physician:_____Tel: _____

Address:_____

City:_____State:_____Zip:_____

Therapist: _____Tel: _____

Address:_____

City:_____State:_____Zip:_____

How did you hear about us? (Referral by MD/non-MD? Ad? Specific website? Etc…)

Please be precise: _____

If you were referred, who referred you to our practice?

Please be specific: _____

It is our standard practice, a professional courtesy, and the general standard of medical care, to thank referring physicians. We do this by providing the referring doctor and other physicians involved in your care, with a brief summary of your visit, either by letter, or brief telephone call.

Referring Physician/Professional:_____

Tel: _____

Address:_____

City:_____State:_____Zip:_____

If you do NOT wish for us to communicate with other physicians, please indicate:

☐ Do not contact Dr._____ only. You may speak with other physicians involved in my care.

☐ Do not contact any physician about my visit.

If another doctor has specifically referred you, they, or their office, may call us about your visit. We will simply inform them that you do not wish for us to discuss your case with them.

How would you prefer to be reminded about your appointments?

Home tel: ___ Cell tel: ___ E-mail: _____