Office Dx Code: _____

PATIENT INFORMATION

Patient Name _____ **Date** _____

Street Address _____ **City, State** _____ **Zip** _____

Birthdate _____ **SS#** _____ **Phone (home)** _____ **(work)** _____

Employer _____ **Address** _____

Marital Status _____ **Spouse's Name** _____ **Spouse's Employer** _____

If someone other than the patient is responsible for the bill, please provide name, address, employer, and signature of person responsible _____

Patient's primary insurance _____ **Contract #** _____

Insured's name _____ **Insured's relationship to patient** _____

Insured's address _____ **Insured's Employer** _____

Other insurance_____

Please sign here to permit assignment of insurance benefits to us _____

Who referred you to us? _____ **Address** _____

Do we have your permission to send an acknowledgment card to this person? _____

If you were not referred, how did you find this office? _____

Primary care physician _____ **Address** _____

Please sign here if we have permission to exchange relevant clinical information with this physician (an HMO requirement) _____

Please sign here to give permission to exchange relevant clinical information* with the referring person if other than the PCP _____

***(Treatment summaries, progress reports, and phone contact as needed)**

Have you ever received mental health services before? _____ **If yes, from whom and when?** _____

Can we call you at home? _____ **Can we call you at work?** _____