Rochester Psychological Associates
620 Crosskeys Office Park
Fairport, NY 14450

PATIENT INFORMATION

Name _____Date _____

Street Address _____City, State _____ Zip_____

Birthdate _____

Phone(home) _____ (work) _____ (mobile) _____

Employer_____ Address_____

Marital Status _____ Spouse's name_____Spouse's employer_____

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

_____

Patient's primary insurance_____ Contract #_____

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

Insured's address_____ Insured's employer _____

Other insurance_____

Who referred you to us? _____

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

Primary care physician _____

Address_____Phone_____

Sign here if we have permission to exchange relevant clinical information* with this physician (an HMO requirement)

X_____

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

X_____

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