

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 pcp _____

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)