MedPsych ASSOCIATES

**545 Island Road, Suite 2B**
**Ramsey, NJ 07446 * 201-995-1004**

# NEW PATIENT INFORMATION

Please fill out this form and bring it to your first session.

PATIENT NAME: _____ BIRTHDATE: ___/___/___

HOME ADDRESS: _____

CITY: _____ ZIP: _____

TELEPHONE (CELL): _____ (HOME): _____

(WORK): _____

EMAIL: _____

CAN LEAVE MESSAGE: CELL: Y/N HOME: Y/N WORK: Y/N EMAIL: Y/N

OCCUPATION: _____

PERSON RESPONSIBLE FOR PAYMENT: _____

PRIMARY CARE PHYSICIAN: _____

PERSON TO CONTACT IN EMERGENCY: _____ RELATIONSHIP: _____ TELEPHONE: _____

INSURANCE CARRIER: _____

PRIMARY INSURANCE HOLDER: _____DOB: ___/___/___

HOW DID YOU LEARN OF MY PRACTICE: _____

FEE AND CANCELLATION POLICY: A 24-hour cancellation notice is required.

PATIENT/CLIENT AGREEMENT
I understand and agree that I am responsible for the balance on my account for all professional services rendered. I have read all the information on this sheet and certify the information I have provided is true and correct to the best of my knowledge.

SIGNED: _____ DATE: _____
(Patient or Parent/Guardian if Patient is a Minor)