Patient Information Form

First Name

Middle Name / MI

Last Name

Communication Preference

Cell Phone

Home Phone

Work Phone

Email

Patient Address Line 1

Patient Address Line 2

City

State

Zip

Date of Birth

Sex

Marital Status

Social Security Number

Patient Smoking Status

Patient Smoking Frequency

Patient Smoking Start Date

Patient Smoking End Date

Name of Spouse

Spouse Date of Birth

SS#

CA driver's License#

Expiration Date

If patient is a minor

Parent 1

Parent 2

Name of Guardian

Custody Rights

Address if different from above

Emergency Contact

Emergency Contact Name

Emergency Contact Relationship to Patient

Emergency Contact Home Phone

Emergency Contact Cell Phone

Emergency Contact Address Line 1

Emergency Contact Address Line 2

Emergency Contact City

Emergency Contact State

Emergency Contact Zip

Name

Phone Number

Relation

Employment Information

Professional Title

Employer Name

Employer Phone

Employer Address Line 1

Employer Address Line 2

Employer City _____ **Employer State** _____ **Employer Zip** _____

Insurance Information

Insurance provided by _____ **Other** _____ **Type of Insurance** _____ **Other** _____

Primary Insurance Name _____ **Primary Subscriber ID** _____ **Primary Group No.** _____ **Deductible** _____

Primary care physician _____ **Phone Number** _____

Referred by:

Referred by _____ **Name** _____ **Phone** _____

Records Release

I authorize the physician/provider to release any information requested to process this claim and any clinical information necessary for treatment.

Signature

Date _____

Financial Agreement

I understand that I am responsible for collecting my own insurance benefits. Payments on my account will not be delayed or withheld because of pending insurance claims. I understand that all appointments must be cancelled 24 hrs. in advance or I will be charged a No Show fee. Appointments not cancelled within 24 hrs. are subject to charge of $30.00 for medication management and full visit fee for therapy appointments. Should my insurance be cancelled, I will be responsible for fees incurred at the industry standard rates.

Signature

Date _____