NEW PATIENT INFORMATION SHEET

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Maritial Status: S ☐ M ☐ D ☐ W ☐ Domestic Partner ☐ Gender: M ☐ F ☐

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Fax: _____ Email: _____

Employment Status: FT ☐ PT ☐ Unemployed ☐ Student ☐ Disabled ☐ Retired ☐

Type of Employment: _____

Usual Work Hours: _____

Patient's Primary Language: English ☐ Other (specify) ☐ _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Work / Cell: _____

WHAT HAND DO YOU USE PREDOMINATELY? LEFT ☐ RIGHT ☐ BOTH ☐

If you are LEFT handed, are you exclusively LEFT handed? YES ☐ NO ☐

RESPONSIBLE PARTY INFORMATION (if other than the patient)

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PRIMARY INSURANCE INFORMATION (Please attach a copy – front & back of insurance card(s) if available)

Primary Insurance:	Insurance Phone:	Subscriber ID #:
Subscriber Name:	Subscriber Date of Birth:	Group #:
Relationship to Subscriber: Self ☐ Spouse ☐ Other ☐	Is Provider Contracted with This Insurance? Yes ☐ No ☐ Unknown ☐	

SECONDARY INSURANCE INFORMATION (Please attach a copy – front & back of insurance card(s) if available)

Secondary Insurance:	Insurance Phone:	Subscriber ID #:
Subscriber Name:	Subscriber Date of Birth:	Group #:
Relationship to Subscriber: Self ☐ Spouse ☐ Other ☐	Is Provider Contracted with This Insurance? Yes ☐ No ☐ Unknown ☐	

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email Address: _____ Name of Office Contact: _____

Dates under physician care: From: _____ To: _____ Date of last visit: _____

PSYCHIATRIST INFORMATION

Psychiatrist Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email Address: _____ Name of Office Contact: _____

Dates under psychiatrist care: From: _____ To: _____ Date of last visit: _____

Continued on next page

NEW PATIENT INFORMATION SHEET (CONT'D)

Patient Name: ______________________________

OTHER PHYSICIANS, PSYCHIATRISTS, THERAPISTS, HEALTH CARE PROVIDERS

OTHER PROVIDER INFORMATION

Provider Name: ______________________________ Type of Provider: ______________

Address: ______________________________ City: ______________ State: ________ Zip: __________

Phone: ______________________________ Fax: ______________________________

Email Address: ______________________________ Name of Office Contact: ______________________

Dates under provider care: From: __________ To: __________ Date of last visit: ______________

OTHER PROVIDER INFORMATION

Provider Name: ______________________________ Type of Provider: ______________

Address: ______________________________ City: ______________ State: ________ Zip: __________

Phone: ______________________________ Fax: ______________________________

Email Address: ______________________________ Name of Office Contact: ______________________

Dates under provider care: From: __________ To: __________ Date of last visit: ______________

OTHER PROVIDER INFORMATION

Provider Name: ______________________________ Type of Provider: ______________

Address: ______________________________ City: ______________ State: ________ Zip: __________

Phone: ______________________________ Fax: ______________________________

Email Address: ______________________________ Name of Office Contact: ______________________

Dates under provider care: From: __________ To: __________ Date of last visit: ______________

OTHER PROVIDER INFORMATION

Provider Name: ______________________________ Type of Provider: ______________

Address: ______________________________ City: ______________ State: ________ Zip: __________

Phone: ______________________________ Fax: ______________________________

Email Address: ______________________________ Name of Office Contact: ______________________

Dates under provider care: From: __________ To: __________ Date of last visit: ______________

SIGNATURE / AUTHORIZATION

I authorize the release of any medical information necessary to process my claim.

I hereby authorize examination and whatever services deemed necessary. I agree to assume financial responsibility for all services provided.

I authorize the release of any medical information to the health care providers listed above.

Signature of Patient or Responsible Party: ______________________________

Date: ______________________________