



55 North Gilbert Street  
Suite 2203  
Tinton Falls, New Jersey 07701

(732) 740-7675 Telephone  
(732) 842-0100 Fax  
www.thetmscenterofnj.com

## NEW PATIENT INFORMATION SHEET

Patient Name: _____		Date of Birth: _____	
Address: _____		City: _____ State: _____ Zip: _____	
Marital Status: S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Domestic Partner <input type="checkbox"/>		Gender: M <input type="checkbox"/> F <input type="checkbox"/>	
Home Phone: _____		Work Phone: _____ Cell Phone: _____	
Fax: _____		Email: _____	
Employment Status: FT <input type="checkbox"/> PT <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/>			
Type of Employment: _____			
Usual Work Hours: _____			
Patient's Primary Language: English <input type="checkbox"/> Other (specify) <input type="checkbox"/> _____			
Emergency Contact: _____		Relationship: _____	
Phone: _____		Work / Cell: _____	
WHAT HAND DO YOU USE PREDOMINATELY? LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BOTH <input type="checkbox"/>			
If you are LEFT handed, are you exclusively LEFT handed? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>RESPONSIBLE PARTY INFORMATION (if other than the patient)</b>			
Name: _____		Relationship to patient: _____	
Address: _____		City: _____ State: _____ Zip: _____	
Home Phone: _____		Work Phone: _____ Cell Phone: _____	
<b>PRIMARY INSURANCE INFORMATION (Please attach a copy – front &amp; back of insurance card(s) if available)</b>			
Primary Insurance: _____		Insurance Phone: _____	Subscriber ID #: _____
Subscriber Name: _____		Subscriber Date of Birth: _____	Group #: _____
Relationship to Subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other <input type="checkbox"/>		Is Provider Contracted with This Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
<b>SECONDARY INSURANCE INFORMATION (Please attach a copy – front &amp; back of insurance card(s) if available)</b>			
Secondary Insurance: _____		Insurance Phone: _____	Subscriber ID #: _____
Subscriber Name: _____		Subscriber Date of Birth: _____	Group #: _____
Relationship to Subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other <input type="checkbox"/>		Is Provider Contracted with This Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
<b>PRIMARY CARE PHYSICIAN INFORMATION</b>			
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: _____			
<b>PSYCHIATRIST INFORMATION</b>			
Psychiatrist Name: _____			
Address: _____		City: _____ State: _____ Zip: _____	
Phone: _____		Fax: _____	
Email Address: _____		Name of Office Contact: _____	
Dates under psychiatrist care: From: _____ To: _____ Date of last visit: _____			

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### NEW PATIENT INFORMATION SHEET (CONT'D)

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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: \_\_\_\_\_