NEW PATIENT INFORMATION FORM

PATIENT'S NAME: _____ MALE ☐ FEMALE ☐

PATIENT'S BIRTHDATE: _____ PATIENT'S MARITAL STATUS: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

APPOINTMENT CONFIRMATION PREFERENCE: TEXT ☐ PHONE CALL ☐ BEST #: _____

NAME OF PRIMARY CARE PHYSICIAN/PEDIATRICIAN: _____

SCHOOL: _____ GRADE: _____

IF PATIENT IS A MINOR (UNDER 18 YEARS OLD) PLEASE COMPLETE THE FOLLOWING SECTION:

FATHER'S NAME: _____ DATE OF BIRTH: _____

ADDRESS (IF DIFFERENT): _____

PLACE OF EMPLOYMENT: _____ PHONE: _____

MARITAL STATUS: _____

MOTHER'S NAME: _____ DATE OF BIRTH: _____

ADDRESS (IF DIFFERENT): _____

PLACE OF EMPLOYMENT: _____ PHONE: _____

MARITAL STATUS: _____

MEDICAL INSURANCE INFORMATION (MUST BE COMPLETED EVEN IF COPY OF CARD WAS TAKEN)

INSURANCE CARRIER: _____ SUBSCRIBER'S NAME: _____

SUBSCRIBER DATE OF BIRTH: _____ RELATION TO PATIENT: _____

INSURANCE ID #: _____ CLASS OR GROUP: _____

IS PATIENT COVERED BY OTHER MEDICAL INSURANCE? IF YES, PLEASE COMPLETE THE FOLLOWING:

INSURANCE CARRIER: _____ SUBSCRIBER'S NAME: _____

SUBSCRIBER DATE OF BIRTH: _____ RELATION TO PATIENT: _____

INSURANCE ID #: _____ CLASS OR GROUP: _____

HAVE YOU HAD ANY OTHER MENTAL HEALTH VISITS THIS YEAR? IF SO, HOW MANY? _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process any insurance claim(s). I also authorize payment of medical benefits for services described on above-mentioned claim(s). I understand that I am ultimately responsible for payment of all services rendered, for payment of any reasonable attorney fees and all cost of suit if a legal suit is instituted to enforce collection of accounts past due, and recognize ***that I will be charged for appointments if canceled with less than 24 hours notice****. If I participate in a managed care company and authorization is denied for treatment, it is understood that I will be billed directly for services provided.* ***I understand that all co-pays, deductibles, or private pay fees are due at time of service****. I recognize that East Amherst Psychology Group is a Limited Liability Partnership. The primary care physician may be consulted.*

SIGNED: _____ DATE: _____

PRINTED NAME: _____