Psychology CONSULTANTS INC.

NEW PATIENT INFORMATION

Date:_____

PATIENT

First Name:_____ Marital Status:_____
Last Name:_____ Sex: M____ F_____
Street Address:_____
City:_____ State/Zip Code:_____

Social Security Number:_____ Date of Birth:_____
Home Phone: ( ) _____ Cell Phone: ( ) _____
Place of Employment:_____ Address:_____
_____

Relation to Insured: Self____ Spouse____ Child:_____
Emergency Contact Name:_____Number:_____Relation:_____

INSURANCE INFORMATION

Insurance Carrier:_____ Policy Holder:_____
Policy Holder DOB:_____ Policy Holder SS#:_____
Member ID:_____ Policy Group #:_____
Home Phone:_____ Work Phone:_____
Place of Employement:_____

COORDINATION OF CARE

Authorization for communication with PCP? Yes_____ No_____

Date of communication with PCP (if authorized): _____

For Office Use Only

Date office verified insurance:_____ Spoke with:_____

Is a Pre-Cert/Authorization Required? Yes___ No___ If yes, how many?_____

Start date of authorization_____ to End date_____