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LICENSED PSYCHOLOGIST

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DEMOGRAPHIC INFORMATION

Patient name: _____ Date of birth: _____ Date of first appointment: _____

Address: _____ City: _____ State: _____ Zipcode: _____

Patient gender: _____ Ethnicity: _____ Phone number: _____

Appointment reminders by text: YES NO Email: _____

Spouse's name: _____

Parent's name (if patient is under 19): _____ Parent's date of birth: _____

Who has the right to give legal consent for medical treatment? _____

Is this right shared with anyone else? YES NO *If parents are divorced, please bring documentation.

Will you be using insurance? YES NO If YES, please answer ALL questions below.

Primary insurance company: _____

Member ID: _____ Group/Plan Number: _____

Policy holder's name: _____ Relationship to patient: _____

Policy holder's Social Security number: _____ Policy holder's date of birth:_____

Secondary insurance company: _____

Member ID: _____ Group/Plan Number: _____

Policy holder's name: _____ Relationship to patient: _____

Policy holder's Social Security number: _____ Policy holder's date of birth:_____

Responsible party or guarantor (if other than patient): _____

Address: _____ Phone: _____