NEW PATIENT INFORMATION **OFFICE VISIT FORM**

PATIENT NAME: _____ HOME PHONE: _____

HOME ADDRESS: _____ WORK PHONE: _____

_____

(city) (state) (zip code)

SOCIAL SECURITY NUMBER: (Patient) _____

(Parent/Guardian) _____

PATIENT: SEX: _____ AGE: _____ DATE OF BIRTH: _____ MARITAL STATUS: _____

IF PATIENT IS A CHILD:

SCHOOL: _____

GRADE: _____ TEACHER: _____

IF PATIENT IS A CHILD, WHO HAS LEGAL CUSTODY: _____

WHO REFERRED YOU TO THIS OFFICE: _____

HAS THE PATIENT BEEN SEEN BY A THERAPIST BEFORE: ____ IF YES, HOW LONG AGO: _____
WAS PSYCHOLOGICAL TESTING DONE: _____ IF YES, HOW LONG AGO: _____

WHERE: _____ NAME OF THERAPIST: _____

THE FOLLOWING INFORMATION IS ESSENTIAL TO COORDINATING YOUR CARE.

FAMILY PHYSICIAN/PEDIATRICIAN: _____
ADDRESS/LOCATION & PHONE #: _____
_____

I DO_____ DO NOT_____ GIVE PERMISSION TO MY PROVIDER TO RELEASE INFORMATION ABOUT MY CURRENT TREATMENT TO MY PRIMARY CARE PHYSICIAN.

MEDICATIONS TAKEN AT THIS TIME (please indicate name of medication and dosage): _____

DID YOU READ AND UNDERSTAND OUR BILLING POLICY? _____

****IF YOU HAVE PROBLEMS WITH FINANCES AND CANNOT SATISFACTORILY WORK THEM OUT WITH THE OFFICE STAFF, PLEASE FEEL FREE TO TALK WITH YOUR THERAPIST****

_____ _____

Signature (Patient-Parent/Guardian) Date

Revised 12/06

HEALTH INSURANCE CLAIM FORM

PATIENT'S NAME:_____

PATIENT'S ADDRESS:_____

TELEPHONE # (Include area code):_____

PATIENT'S BIRTH DATE:_____

PATIENT RELATIONSHIP TO INSURED:_____

INSURED'S ID NUMBER:_____

INSURED'S NAME:_____

INSURED'S ADDRESS:_____

TELEPHONE # (Include area code):_____

INSURED'S POLICY GROUP OR FECA NUMBER:_____

INSURED'S DATE OF BIRTH:_____

SEX: M_____ F _____

EMPLOYER'S NAME OR SCHOOL NAME:_____

INSURANCE PLAN NAME OR PROGRAM NAME:_____

IS THERE ANOTHER HEALTH BENEFIT PLAN? YES_____ NO _____
IF YES, PLEASE PROVIDE INSURANCE ID#_____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:
(I authorize the release of any medical or other information necessary to process this claim.)

SIGNED_____ DATE_____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:
(I authorize payment of medical benefits to the undersigned physician or supplier for services.)

SIGNED_____DATE_____