Adult - Patient Information

Patient Name ____

Mailing Address:

Street______________________________ Home Telephone: ______________________

P O Box ______________________________ Cell Telephone: ______________________

City/State/Zip______________________________ Work Telephone: ______________________

SSN ________________ Date of Birth ____________ Age _____ Gender (circle) Male Female

Marital Status (circle) S M Wid. Sep. Div. No. of Children ___

Name of Employer ______________________Occupation ______________________

Spouse ______________________Employer/Occupation ______________________

Referred By ______________________ Primary Care Physician (PCP) ______________________

I am responsible for all financial aspects of this account.

Signature____ Date ______________

INSURANCE INFORMATION

Primary Insurance:

Insured Name ______________________ Employer ______________________

Date of Birth______________ SSN ________________Relationship to Patient ______________

Secondary Insurance:

Insured Name ______________________ Employer ______________________

Date of Birth______________ SSN ________________Relationship to Patient ______________

I hereby authorize the release of psychological information necessary to process this and future claims and request payment on assigned claims be made directly to Clinical Psychology of Fort Smith.

Signature ____ Date ______________