WellSpring Child and Family Psychology, PC

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Patient Information Form (Adult)

Patient Information:
Last Name:_____ Middle:_____ First:_____
Preferred Name/Nickname:_____
Date of Birth:_____ Gender:_____
Marital Status: Married____ Single____ Separated____ Divorced____

Contact Information:

Address:_____
City:_____ State:_____ Zip Code:_____
Cell Phone:_____ Ok to leave voicemail? yes ____ no____
Home Phone:_____ Ok to leave voicemail? yes ____ no____
Work Phone:_____ Ok to leave voicemail? yes ____ no____
Other Phone:_____
Email Address:_____ Email me appointment reminders: yes___ no___
Emergency Contact:_____ Phone:_____
Relation to Emergency Contact:_____
(your provider may attempt to contact this person in case of emergency)

Insurance Information: (please initial beside one choice below)

___ I have in-network insurance. I will be responsible for copays/coinsurance, deductibles, and uncovered fees. I will contact insurance to ensure coverage.
___ I will use insurance, but since provider is out-of network, I will be responsible for paying in full for sessions and submitting claims myself.
___ I do not have insurance and would like to self-pay for sessions.

Insurance:_____ ID#:_____
Group #:_____ Effective Date:_____
Policy Holder Name:_____ Policy Holder DOB:_____
Policy Holder SSN:_____
Insurance Contact Number (for Mental Health/Providers):_____
Insurance Billing Address:_____
Do you have any other insurance coverage? yes____ no____

Please list all current medications including dose and prescribing physician:
_____
_____