

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.

Primary Insurance: _____ ID#: _____

Group #: _____ Effective Date: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Secondary Insurance: _____ ID#: _____

Group #: _____ Effective Date: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Please list all current medications including dose and prescribing physician:

