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:
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