PATIENT INFORMATION

TODAY'S DATE_____

Patient Name_____ DOB_____

Address_____ City_____ State_____ ZIP_____

Home Phone_____ Work_____ Cellular_____

Age_____ SSN_____ Male or Female Single Married Divorced Other

If applicable, the child is in legal custody of _____

Employer or School _____

Primary Care Physician_____ Referring Physician_____

Individual(s) we can contact in the event of an emergency_____

Phone Number_____ Relationship_____

May we contact you and/or leave messages on your cell phone, landline and/or voicemail? Yes No

GUARANTOR (IF PATIENT IS A MINOR, THIS PERSON WILL BRING THE MINOR TO THE APPTS)

Name_____ DOB_____ SSN_____

Relationship to Patient _____ Employer_____

Address_____ City_____ State_____ Zip_____

Work Phone _____Home Phone_____

PRIMARY INSURANCE_____ **POLICY HOLDER**_____

SSN_____ Policy Holder's DOB_____ Policy ID#_____

Employer_____ Phone_____

SECONDARY INSURANCE_____ **POLICY HOLDER**_____

SSN_____ Policy Holder's DOB_____ Policy ID#_____

Employer_____ Phone_____

I have been informed of the Notice of Privacy Practice and Patient Rights and Responsibilities of Psychological Assessment Specialists, PLLC. I am giving my consent, in case of an emergency, to contact my emergency contact listed above. By signing below, you or any one accompanying you, agree not to bring firearms or any other dangerous weapon/substance onto the property of PAS. I understand that I have chosen Psychological Assessment Specialists as my mental health care provider. I am aware that a written copy of any of the above stated policies are available to me upon request. I attest, to the best of my knowledge, that the above information provided on this form is true and correct.

_____

Patient or Legal Guardian Signature Date