

SILVERMAN & ASSOCIATES, Inc.

PSYCHOLOGICAL & COUNSELING SERVICES

PATIENT INFORMATION

| | | | | | | | |
|--|----------------------------------|--|--|---|---|--|---|
| Today's Date: | | Primary Care Physician: | | Practice: | | Phone: () | |
| Patient's Name: | | | <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. | | Marital status: | | |
| Last: | First: | Middle: | | | <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed | | |
| Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? | (Former name): | | Birth date: | | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Street address: | | | Social Security #: | | | Home phone #: () | |
| | | | | | | Cell Phone #: () | |
| P.O. Box: | | City: | | State: | | ZIP Code: | |
| Occupation: | | Employer: | | | Employer phone#:() | | |
| Email Address: | | | | | | | |
| How were you referred to us? (Please check one box): | | | <input type="checkbox"/> Insurance plan <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Hospital <input type="checkbox"/> PCP | <input type="checkbox"/> Family <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work | |
| Is this a child? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Is there a custody arrangement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | | Custodial Parent: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ | | | |
| Parents Names and Contact Info : | | Mother: | | Father: | | Alt. Parent Contact Phone: () | |

INSURANCE INFORMATION

| | | | | | | | |
|--|-----------|----------------------|-------------------------|--|--------------------|----------------------------|------------------|
| (Please give your insurance card to the receptionist upon visit.) | | | | | | | |
| Person responsible for bill: | | Birth date: | Address (if different): | | | Home phone #: () | |
| Occupation: | Employer: | Employer address: | | | | Employer phone#: () | |
| Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Please indicate primary insurance: | | | | | | | |
| Subscriber's name: | | Subscriber's S.S. #: | Birth date: | | Group no.: | Policy no.: | Copayment: \$ |
| Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: | | | | | | | |
| Is treatment due or related to an accident?: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | Attorney Involved: | | |
| If yes, What insurance will be billed: | | | | | Phone: () | | |
| Name of secondary insurance (if applicable): | | Subscriber's name: | | | Group #: | | Policy #: |
| Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: | | | | | | | |

IN CASE OF EMERGENCY

| | | | | | | | |
|--|--|--------------------------|--|-------------------------|--|-------------------------|--|
| Name of local friend or relative (not living at same address): | | Relationship to patient: | | Home phone #: () | | Work phone #: () | |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Provider. I understand that I am financially responsible for any balance. I also authorize Silverman & Associates, Inc., associated billing service provider or insurance company to release any information required to process my claims. | | | | | | | |
| Patient/Guardian signature: _____ | | | | | | Date: _____ | |