

Horizon Psychological Services, P.C.

INFORMATION FORM

(Please Print)

Today's date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
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 no.:		Home phone no.: ()		
City:		State:	ZIP Code:		Cell phone no.: ()		
Occupation:		Employer/School:			Employer phone no.: ()		
E-mail address:			Best method for rapid communication?		It is ok to leave a message on:		
			<input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> E-mail		<input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> E-mail		
Would you like to receive text reminders about appointments? Please provide your cell phone provider if so:							
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Internet search	<input type="checkbox"/> Other			

INSURANCE INFORMATION							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ()	
Occupation:	Employer:	Employer address:			Employer phone no.: ()		
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. no.:	Birth date: / /	Group no.:	Policy no.:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Subscriber's address (if different):							

IN CASE OF EMERGENCY				
Name of local friend or relative:		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the psychologist. I understand that I am financially responsible for any balance. I also authorize Horizon Psychological Services, P.C. or my insurance company to release any information required to process my claims.</p>				
<hr/> <i>Patient/Guardian signature</i>			<hr/> <i>Date</i>	