

# Horizon Psychological Services, P.C.

## INFORMATION FORM

### PATIENT INFORMATION

Patient's last name:		First:	Middle:	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.:	
						( )	
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"/> E-mail		<input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> E-mail		
Mother/Father/Legal Guardian #1 (circle relationship):		Parent DOB:		Parent home phone:		Parent's cell/work phone no.:	
Parent's street address (if different):				City:		State:	ZIP Code:
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		
Mother/Father/Legal Guardian #2 (circle relationship):		Parent DOB:		Parent home phone:		Parent cell/work phone no.:	
Parent's street address (if different):				City:		State:	ZIP Code:
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 text reminders about appointments? If so, please provide your cell carrier's name:							
Chose clinic because/Referred to clinic:				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital

### INSURANCE INFORMATION

Person responsible for bill:		Birth date:	Address (if different):		Home phone no.:	
		/ /			( )	
Occupation:	Employer:	Employer address:			Employer phone 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	

### IN CASE OF EMERGENCY

Name of local friend or relative:		Relationship to patient:	Home phone no.:	Work phone no.:
			( )	( )

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.

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date