Horizon Psychological Services, P.C.
INFORMATION FORM
(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Ms. ❑ Mx.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Gender: ❑ M ❑ F ❑ NB

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:
	❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ E-mail	❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ 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):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Internet search	❑ 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?	❑ Yes	❑ No

Please indicate primary insurance	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ 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.: ( )

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*