Horizon Psychological Services, P.C.
INFORMATION FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Birth date: / /	Age:	Gender: ❑ M ❑ F ❑ NB
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:
	❑ Home Phone ❑ Cell Phone ❑ E-mail	❑ Home Phone ❑ Cell Phone ❑ 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:
	❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ E-mail	❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ 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:
	❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ E-mail	❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ E-mail

Would you like text reminders about appointments? If so, please provide your cell carrier's name:		
Chose clinic because/Referred to clinic:	❑ Dr.	❑ Insurance Plan ❑ 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:	❑ Self	❑ Spouse	❑ Child	❑ 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*