Weston Psychological Associates

Personal Information

Today's date: _____Your appointment is with: _____

A. Identification

Your name: _____Date of birth: _____ Age: _____

Your E-mail address: _____ Social Security #: _____

May we use your e-mail to communicate with you? ____yes _____no

May we confirm your appointment via text message? ____yes _____no

Home street address: _____ Apt._____

City:_____State:_____Zip:_____Home/evening phone: _____ Cell #:_____

Calls will be discreet, but please indicate any restrictions:_____

B. Your current employer

Employer: _____ Address: _____

Occupation:_____

Work phone: _____Calls will be discreet, but please indicate any restrictions: _____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? □ Yes □ No

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D. (If applicable)

Spouse's name: _____ Birthdate: _____ Soc. Sec. #: _____

Occupation:_____ Employer: _____ Work phone: _____

Address of employer: _____

Please complete the other side

E. Referral: Referred by:

- Internet search
- Goggle
- Facebook
- Instagram
- Insurance Carrier
- Other:_____

Name: _____ Phone: _____

Address: _____

_____

May I have your permission to thank this person for the referral? □ Yes □ No

F. Emergency Contact: _____

Telephone # _____Relationship: _____

F. Are you involved in a lawsuit or any legal proceedings? If yes, what is the nature of the suit?

_____

Name and phone # of Attorney: _____

G. I understand that I am responsible for all charges, regardless of insurance coverage. _____Initials

H. I give this office permission to release any information obtained during examinations or treatment, to my insurance company, to support any insurance claims on this account and secure timely payments due to the assignee or myself. _____Initials

I. Assignment of benefits:

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Weston psychological Associates. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

_____ _____

Patient's signature, indicating agreement to all of the statements above — Date

_____

Printed name

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