Patricia J. LaFave, Ph.D. and Associates, P.C.

ADULT IDENTIFYING INFORMATION

PATIENT NAME:_____

DATE OF BIRTH: _____ **HOME PHONE:**_____

CELL PHONE: _____ **WORK PHONE:**_____

PLEASE CHECK THE PREFERRED PHONE NUMBER TO REACH YOU. □ HOME □ CELL □ WORK

STREET ADDRESS: _____

CITY: _____ **ZIP CODE:**_____

EDUCATION: (HIGHEST LEVEL COMPLETED)_____ **OCCUPATION:** _____

PATIENT'S SOCIAL SECURITY NO: _____ – _____ – _____ **(MEDICARE OR TRICARE ONLY)**

EMPLOYER NAME: _____

MARITAL STATUS: _____ **SPOUSE NAME:** _____

SPOUSE DATE OF BIRTH: _____**ADDRESS (IF DIFFERENT):** _____

NAME & AGE OF CHILDREN: _____

_____

EMERGENCY CONTACT*: _____ *PHONE NUMBER: _____

REFERRED BY:_____ **REASON FOR REFERRAL:** _____

****

INSURANCE INFORMATION

MEDICAL INSURANCE #1: _____ **PHONE NO:** _____

POLICY NO: _____ **GROUP NO:** _____

SUBSCRIBER NAME: _____ **SUBSCRIBER DATE OF BIRTH:** _____

SUBSCRIBER'S EMPLOYER:_____

MEDICAL INSURANCE #2: _____ **PHONE NO:** _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

SUBSCRIBER NAME: _____ **SUBSCRIBER DATE OF BIRTH:** _____

SUBSCRIBER'S EMPLOYER: _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND PAYMENT OF MEDICAL BENEFITS TO THERAPIST

SIGNATURE OF PATIENT: _____ **DATE:** _____