# CHURCHLAND PSYCHOLOGICAL CENTER

# NEW PATIENT INFORMATION DATE*: \_\_\_/\_\_\_/\_\_\_\_\_*

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Patient’s Last Name First Name M.I. Sex Birth Date Age SS#

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Responsible Party (if Minor) Birthdate S# Relationship to Patient

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Billing Address City State Zip Code

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Referred by Employer (Name & Address)

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Home Phone Leave Message? Y \_\_ N \_\_ | Work Phone Leave Message? Y \_\_N \_\_ | Cell Phone Leave Message ? Y \_\_N\_\_

***Do you want communications with your therapist via text message or email*** (**Non-protected environment)** Y\_\_\_N\_\_\_

***Please Complete This Section Even If We Photocopied Your Card***

#### Primary Insurance Information

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Policy Holder: Last Name First Name M.I. Sex Birth Date Home Phone

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Address City State Zip code Employer/School SS#

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Insurance company name Insured ID# Insured Group#

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Insurance address City State Zip code

Circle Patient’s Relationship to Insured*:* **Self Spouse Child Other**  Authorization #

#### Secondary Insurance Information

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Address City State Zip Code Employer/School SS#

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Insurance company name Insured ID# Insured Group#

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Insurance address City State Zip Code

Circle Patient’s Relationship to Insured: **Self Spouse Child Other**  Authorization #

***SIGN and DATE “New Patient Agreement” on Reverse Side. Thank You!***

Do Not Write Below This Line (This Portion To Be Completed by Therapist After Initial Visit)

Therapist Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DX : (Include ICD-10 Code) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary DX\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_