PSYCHOLOGICAL SERVICES OF PENDLETON, LLC
GENERAL INFORMATION FORM

Please complete the information below and bring with you to your first appointment.

PATIENT:_____ _____
Date of Birth

Address: _____ _____
Mailing Address, City, State, Zip Code **Social Security #**

Home #:_____Work #:_____Cell #:_____
***May we contact you at the above numbers to remind you of your appointment*?** **Home □ Work □ Cell □**
Gender: Male □ or Female □ Marital Status: Married □ Single □ Divorced □ Widowed □

Employer: _____ _____
Name & Address **Phone Number**

Emergency Contact
Name & Phone #: _____ _____
Please check one: Spouse□ Parent□ Guardian□ Friend□ **Contact's Employer**

_____ _____
Primary Doctor or Care Provider's Name and Address **Phone Number**

_____ _____
Pharmacy Name, City **Phone Number**

_____ _____
Primary Insurance **Name and Claims Address** **Subscribers Name**

_____ _____ _____
Policy Number **Group Number** **Employer**

_____ _____
Secondary Insurance **Name and Claims Address** **Subscribers Name**

_____ _____ _____
Policy Number **Group Number** **Employer**

Do you see another mental health professional? YES □ NO □ _____
Name and Phone Number

My signature on this form authorizes contact with my doctor or primary care provider. My signature on this form authorizes the release of medical information necessary to process this claim for my insurance company. My signature on this form authorizes payment of insurance benefits to my treating provider. Sending claims to my insurance company is a service provided by Psychological Services of Pendleton, LLC. By signing this form, I certify that I am legally responsible for any charges incurred for this provider**.**

_____
SIGNATURE **DATE**

Please have your insurance card available at the time of your appointment so we may photo copy it!
REMINDER, YOUR CO-PAYMENTS ARE DUE AT THE TIME OF VISIT!