

PSYCHOLOGICAL SERVICES OF PENDLETON, LLC
GENERAL INFORMATION FOR ADULT

PATIENT: _____ / _____ / _____
 First **Middle** **Last** **Date of Birth**
Gender: Male ☐ or Female ☐ **Age:** _____ **Marital Status:** Married ☐ Single ☐ Divorced ☐ Widowed ☐

Address: _____ - _____ - _____
 Street **Mailing if Different** **Social Security #**

 City **State** **Zip Code**

Home #: _____ **Work #:** _____ **Cell #:** _____
May we contact you at the above numbers and leave messages? Home ☐ Work ☐ Cell ☐

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

Spouse/Significant Other: _____ / _____ / _____
 First **Last** **Middle Initial** **Date of Birth**

Work #: _____ **Cell #:** _____
 - - -
 Social Security #

Spouse/Significant Employer: _____
 Name & Address **Phone Number**

Emergency Contact: _____
 First **Last** **Phone Number**
Relationship to Emergency Contact: Spouse ☐ Parent ☐ Guardian ☐ Friend ☐ Other ☐ _____

 Primary Doctor or Care Provider's Name **Phone Number**

 Pharmacy Name, City **Phone Number**

Primary Insurance **Claims Address** **Subscribers Name/Relationship**
Subscriber's address if different from patient: _____

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

Secondary Insurance **Claims Address** **Subscribers Name/Relationship**
Subscriber's address if different from patient: _____

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

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

REMINDER: YOUR CO-PAY/CO-INSURANCE IS DUE AT THE TIME OF EACH VISIT!