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 ☐**

E-mail Address: _____
May we contact you by E-mail? Yes No

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 **Subscribers Name/Relationship** **Subscriber DOB**
Subscriber's address if different from patient: _____

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

_____ _____
Secondary Insurance **Subscribers Name/Relationship** **Subscriber DOB**
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!