

NEW PATIENT INFORMATION

Date: _____

YOUR PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____

Apt. _____ City: _____ State: _____ Zip: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Email address: _____

Social Security #: _____ - _____ - _____

Date of Birth: _____ - _____ - _____ Age: _____

YOUR EMPLOYMENT INFORMATION

Occupation: _____

Employer: _____

Address: _____

Phone: _____ how long at this place? _____

Previous job & employer _____

YOUR EDUCATIONAL INFORMATION

Highest grade finished: _____ Year _____ Degree: _____

If attended college, specify major (s) _____

YOUR HEALTH HISTORY

Primary Care Physician: _____

Address: _____

Phone: _____

Are you experiencing now, or have you experienced in the past, significant health problems? Y N

Please list if any:

YOUR PREVIOUS COUNSELING HISTORY

Have you ever been treated by a psychiatrist, psychologist, licensed clinical social worker, or any other mental health worker? Y N

If yes, please specify:

Therapist's Name	Dates	Reasons	For How Long	Were You Satisfied?

Have you ever been hospitalized for psychiatric reasons? Y N

If yes, please explain:

MEMBERS OF YOUR FAMILY OF ORIGIN

Father's name: _____
If living, age: _____
If deceased, when and cause of death _____
Occupation _____

Mother name: _____
If living, age: _____
If deceased, when and cause of death _____
Occupation _____

Have your parents ever divorced? Y N
If yes, how old were you when they divorced? _____

Do you have any brothers or sisters? Y N
Please list them by order of birth:

Name	Age	Married?	Children (#)	Living?

YOUR SIGNIFICANT LOSSES

Please list any significant losses you have experienced throughout your life:

- | | |
|-----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |
| 11. _____ | 12. _____ |
| 13. _____ | 14. _____ |
| 15. _____ | 16. _____ |

Do you have any children from other relationships?

Name (First and last)	age/ date of birth	M / F	Living with you?

OTHER CURRENT HOUSEHOLD MEMBERS

Name/Relationship	Date of Birth	Male/Female	Dependent? Y or N

PARTY RESPONSIBLE FOR PAYMENT

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

INSURANCE INFORMATION

Please note: If you have out of network benefits I will be happy to provide you with a monthly insurance claim to send it off to your insurance carrier, in order to be reimbursed.

Insurance Company _____

Member/Subscriber Number _____

Group Number: _____ Plan Number: _____

Authorization Number: _____

Number of Sessions Authorized: _____ Time Span Authorized: _____

Number of sessions per year: _____ Copayment: _____

For out of network benefits, what is your deductible: _____

Insurance Phone Number: _____

Insurance Address: _____

IF INSURED IS DIFFERENT FROM PATIENT, PLEASE COMPLETE THIS SECTION ALSO

Name of insured (if different than patient): _____

Social Security of member/subscriber: _____

Date of birth: _____ Employer: _____

Relationship to patient: _____

SECONDARY INSURANCE INFORMATION, IF APPLICABLE

Insurance Company: _____ Name of insured: _____

Phone Number: _____ Address: _____

INFORMED CONSENT TO UTILIZE INSURANCE BENEFITS

Authorization for Release of Medical Information

Open communications between your psychotherapist and the primary physician is very important. It is also required by the insurance company in order to continue authorizing further treatment for you, if needed.

Please give your consent and authorization to release the necessary information to your primary physician.

I HEREBY AUTHORIZE MS. DITA TEITELBAUM, LCSW TO RELEASE RELEVANT MEDICAL INFORMATION TO MY PRIMARY PHYSICIAN.

Patient's Name (please print)

Patient's signature

Date

Therapist's signature

Date