

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!