PSYCHOLOGICAL SERVICES OF PENDLETON, LLC.-ADULT INFO.

IDENTIFYING INFORMATION:

Name: First M.I. Last	Soc. Security #:	Date of Birth:	Age:
Address: City: State: Zip Code:			
Home Phone:	Work phone:	Cell Phone:	
Can we leave message at: **Home** □Yes □No	**Work Phone** □Yes □No	**Cell Phone** □Yes □No	
Email Address:	May we contact via email: □Yes □No	Gender: □ Male □ Female □Gender Fluid	
Race/Ethnicity:			

FAMILY INFORMATION:

Marital Status: □Married □ Single □Divorced □Widowed

Spouse/Partner/Significant other's: Can we call this number? □Yes □No

Name:	Phone Number:	Employer:

EMERGENCY CONTACT:

Name	Phone Number	Relationship to contact

PRIMARY CARE PROVIDER:

Name:	Phone Number:

PRIMARY INSURANCE COMPANY:

Company:		Phone Number:
ID Number:	Group Number:	Subscriber Employer:
Subscriber's Name:	Date of Birth:	Patient's relationship to subscriber:
Address if different from patient:		

SECONDARY INSURANCE COMPANY:

Company:		Phone Number:
ID Number:	Group Number:	Subscriber Employer:
Subscriber's Name:	Date of Birth:	Patient's relationship to subscriber:
Address if different from patient:		

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.

PATIENT/REPRESENTATIVE SIGNATURE **DATE**

INSURANCE CO-PAYMENTS ARE EXPECTED AT THE TIME OF VISIT.

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