**Julien Perille,Psy.D**

**Licensed Psychologist**

|  |
| --- |
| DATE |

**PATIENT INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Information** | **PRIMARY CARE PHYSICIAN** | | | | | | **PATIENT NAME** (LAST, FIRST, MIDDLE) | | | | | | | | | | | | | **SOCIAL SECURITY NUMBER** | |
| **DATE OF BIRTH** | | SEX   M   F | | MARITAL STATUS   Single Widowed   Married  Divorced | | | | | DIAGNOSIS (your clinician will fill this out ) | | | | | | | | | | | PREVIOUS NAME (if changed since last visit) |
| RELIGIOUS AFFILIATIONS (optional): | | | | | | | | | | | | | | | | | | | | |
| **ADDRESS** | | | | | | | | | | | | CITY, STATE, ZIP CODE | | | | | | | | |
| Can we contact you at the above address  Yes  No | | | | | | | | | | | | If No please provide us alternate address: | | | | | | | | |
| **HOME TELEPHONE**  ( ) | | | | | | | E-MAIL (OPTIONAL) | | | | | | | | | FAX (OPTIONAL)  ( ) | | | | |
| Can we call your home phone? Yes No | | | | | | | Can we call your work number below?:  Yes  No | | | | | | | | | Can we call your cell phone number below? Yes  No | | | | |
| EMPLOYER  ( ) | | | | | | | WORK TELEPHONE NUMBER  ( ) | | | | | | | | | **CELL PHONE**  ( ) | | | | |
| ADDRESS | | | | | | | | | | | | CITY, STATE, ZIP CODE | | | | | | | | |
|  | Can we contact you at your work? Yes No | | | | | | | | | | | | OCCUPATION: | | | | | | | | |
|  | **HOW DID YOU HEAR ABOUT ME?**  **** drperillecounseling.com  Psychology Today  White/Yellow pages  Physician referral  Other source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | |
| **Guarantor Information**  **(if patient is a minor)** | RESPONSIBLE PARTY OR CUSTODIAL PARENT | | | | | | | | SUBSCRIBER NAME (LAST, FIRST, MIDDLE) | | | | | | | | | | SOCIAL SECURITY NUMBER | | |
| DATE OF BIRTH | | | SEX  M  F | | RELATIONSHIP OF PATIENT TO SUBSCRIBER | | | | | | | | HOME TELEPHONE NUMBER  ( ) | | | | | | | |
| ADDRESS | | | | | | | | | | | CITY, STATE ZIP CODE | | | | | | | | | |
| EMPLOYER | | | | | | | | | | | | | WORK TELEPHONE NUMBER  ( ) | | | | | | | |
| ADDRESS | | | | | | | | | | | CITY, STATE, ZIP CODE | | | | | | | | | |
| **Emergency**  **Contact** | EMERGENCY CONTACT NAME | | | | | | | | | | | RELATIONSHIP | | | | | | | | | |
| HOME TELEPHONE NUMBER | | | | | | | | | | | WORK TELEPHONE NUMBER | | | | | | | | | |
| ( ) | | | | | | | | | | | ( ) | | | | | | | | | |
| **Spouse or Other Parent**  **(if applicable** | NAME (FIRST, MIDDLE, LAST) | | | | | | | | | | | HOME TELEPHONE NUMBER  ( ) | | | | | | | | | |
| ADDRESS (if different than patient) | | | | | | | | | | | CITY, STATE, ZIP CODE | | | | | | | | | |
| EMPLOYER | | | | | | | | | | | | | | | WORK TELEPHONE NUMBER  ( ) | | | | | |
| **INSURANCR** | **PRIMARY INSURANCE COMPANY NAME** | | | | | | | | | | | | | | TELEPHONE NUMBER  ( ) | | | | | | |
| ADDRESS | | | | | | | | | | CITY, STATE, ZIP CODE | | | | | | | | | | |
| GROUP NUMBER | CERTIFICATE/POLICY NUMBER | | | | | | | | | EFFECTIVE DATE | | | | | | | RELATIONSHIP TO SUBSCRIBER (INSURED) | | | |
| SUBSCRIBER’S NAME | | | | | | | | | | SUBSCRIBER’S EMPLOYER | | | | | | | | | | |
| **SECONDARY INSURANCE COMPANY NAME** | | | | | | | | | | | | | | TELEPHONE NUMBER  ( ) | | | | | | |
| ADDRESS | | | | | | | | | | CITY, STATE, ZIP CODE | | | | | | | | | | |
| GROUP NUMBER | CERTIFICATE/POLICY NUMBER | | | | | | | | | EFFECTIVE DATE | | | | RELATIONSHIP TO SUBSCRIBER (INSURED) | | | | | | |
| SUBSCRIBER’S NAME | | | | | | | | | | SUBSCRIBER’S EMPLOYER | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional service rendered. I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I request that payment of authorized medical benefits, if any, be made to Psychological and Educational Services on my behalf for any unpaid services rendered by Psychological and Educational Services clinicians.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the release of medical information to the health plan indicated by the information requested by the health plan to determine the payment of medical benefits.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date