updated 12/04/2013

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Clinical Psychologist

CLIENT INFORMATION FORM

Today's Date:__________ Diagnosis Code(s): ______________________________
(please leave blank)

YOUR INFORMATION

Name:____ Email: ______________________________
Okay to email Y N

Parent's name (if client is under 18): ____

Address/City/State/Zip: ____

Home: (________)______________________________ May I call this number? Y N Leave a message? Y N

Work: (________)______________________________ May I call this number? Y N Leave a message? Y N

Cell: (________)______________________________ May I call this number? Y N Leave a message? Y N

SS#:__________________________ Date of Birth:______________ Employer: ______________________

Occupation:__________________________ Name of Spouse/Partner (if applicable): ____________________

Emergency Contact:________________________________ Phone Number: (________) ____________________

It is okay to contact this person: ____
Client Signature Date

School Attending (if applicable): ____

Name of person referring you:____________________________________ May I thank them for the referral? Y N

PERSON RESPONSIBLE FOR PAYMENT (IF NOT YOU):____________________________ Relationship: ______________

Billing Address with City/Zip Code: ____

Contact #:_______________ Employer:____ SS#: ____________________

INSURANCE INFORMATION (Complete in full and provide a photocopy of your card) Is condition result of an accident? Y N

If yes, Date of Injury:____________ Type of Injury: Auto [ ] Work Related [ ] Other [ ] ____________________________

Name of Case Manager:________________________________ Telephone number: (________)____________________

Primary: Insurance Company:____ Phone #: (_________)____________________

Address of Ins Co: ____

Subscriber Name:________________________________ Relationship:______________ Date of Birth: ______________

ID #:____ Group #: ____________________________________

Secondary: Insurance Company:______________________________________ Phone #: (_________)____________________

Address of Ins Co: ____

Subscriber Name:________________________________ Relationship:______________ Date of Birth: ______________

ID #:____ Group #: ____________________________________

SIGNATURE/AGREEMENT

I hereby give my consent for psychological consultation and treatment. I understand that Dr. Murphy is an independent practitioner. I agree to be financially responsible for all charges for treatment and/or cancelled appointments as outlined in Dr. Murphy's financial policy. I authorize the release of any medical, psychological, or other information necessary to process my insurance claims. I authorize payment of medical/psychological benefits directly to Dr. Murphy.

Signature:____ **Date:** ____________________

CLIENT INFORMATION (continued)

IN CASE OF EMERGENCY CONTACT: (LOCAL FRIEND OR RELATIVE, NOT LIVING AT SAME ADDRESS)

NAME: ____
ADDRESS: ____
CITY: ____
STATE: ____________________ ZIP: ______________ PHONE: ____________________
(Area code) (Number)

Is it okay to contact this person? Y N ____
Signature Date

PRIMARY CARE PHYSICIAN:
NAME: ____
ADDRESS: ____
CITY: ____
STATE: ____________________ ZIP: ______________ PHONE: ____________________
(Area code) (Number)

CURRENT MEDICATIONS:
MEDICINE: ____________________ DOSE: ____________________
MEDICINE: ____________________ DOSE: ____________________
MEDICINE: ____________________ DOSE: ____________________
MEDICINE: ____________________ DOSE: ____________________
MEDICINE: ____________________ DOSE: ____________________
MEDICINE: ____________________ DOSE: ____________________

CURRENT MEDICAL CONDITIONS & HISTORY OF SIGNIFICANT ILLNESS:

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REFERRED TO THIS OFFICE BY: ____