Patient Information Sheet
- Please Print -

Patient:

Name: _____ Today's Date: ___/___/____
Last First Middle MM/ DD/ YY

Address: _____
Number & Street Apt. #

_____
City State Zip Code

Birthdate: ___/___/____ Sex: M [ ] F [ ] Marital Status: _____

Home Phone: (_____) _____-_____ Work: (_____) _____-_____ext_____
Cell : (_____) _____-_____

Responsible Party or Insured:

Name: _____ Date of Birth: ___/___/____
Last First Middle MM/ DD/ YY

Address: _____
Number & Street Apt. #

_____
City State Zip Code

Home Phone: (_____) _____-_____ Work: (_____) _____-_____ext_____

Relationship to Patient: _____ Employer: _____

Employer's Address: _____
Number & Street City State Zip Code

Emergency Information:

Name: _____

Phone Number: (_____)_____-_____ Relationship to Patient: _____

How did you first hear about Laura Barrett, M.A., L.P.C.? _____

Reason for seeking Counseling services: _____

Insurance Information: (Please complete if you wish to use insurance)

Insurance Company: _____ Phone # _____

Address: _____
Number & Street City State Zip Code

Insured's Name: _____ ID #: _____

Group #: _____ Member's Birthdate: ___/___/____

Assignment and Release: I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Laura P. Barrett, M.A., L.P.C., to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Insured or Guardian Date: / /