

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: _____
SS #: _____ - _____ - _____ 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
SS #: _____ - _____ - _____ 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: / /