Your Full Name

Today’s Date

Date of Birth\_\_\_/\_\_\_\_/\_\_\_\_

Current Age\_\_\_\_\_years

Gender

Address where you live:

Phone

Secondary Phone

Email

Who referred you to this clinic?

Emergency Contact Name

Phone

Can this person pick you up in the event of an emergency? Y/N

If not, who can?

Physician Name, Office and Phone Number

Psychiatrist or Prescribing ARNP (if applicable)

Names of Medications and Dosages (List all)

* Med 1
* Med 2
* Med 3
* Med 4

Previous Therapist Name

Dates of Prior Treatment

Have you received formal psychological assessment? Y/N

Dates and name of clinician who conducted previous assessment

INSURANCE FOR BEHAVIORAL HEALTH

**At your first appointment, I will make a photocopy of your insurance cards.**

Are you theindividual who holds the insurance (i.e., the primary subscriber)? Y/N

If yes, what is the name of your employer?

Are you aware of plan coverage for mental health? Y/N

Are you aware of the need for prior authorization or referral for mental health services? Y/N

Complete the information below if you are not the primary subscriber and/OR if you have secondary insurance where you are not the primary subscriber?

Primary Insurance

Patient relationship to insured subscriber

Subscriber name

Date of birth

Gender

Address (if different than above)

Employer Name

Date of insurance expiration or renewal

Secondary Insurance

Patient relationship to insured subscriber

Subscriber name

Date of birth

Gender

Address (if different than above)

Employer Name

Date of insurance expiration or renewal

*Please notify Dr. Lord as soon as any of your insurance information or physical address changes to avoid gaps in coverage. Thank you!*