NEW PATIENT INFORMATION

Date: _________________

YOUR PERSONAL INFORMATION

Last Name: ______________________First Name: ____________________ MI: ______

Address: ____

Apt. ________ City: ___________________ State: _____________ Zip: _____________

Phone Numbers: Home: __________________ Work: __________________ Cell: _________________

Email address: ____

Social Security #: ________ - ________ - ___________

Date of Birth: ________ - _________ - _________ Age: _________

YOUR EMPLOYMENT INFORMATION

Occupation: ____

Employer: ____

Address: ____

Phone: ______________________ how long at this place? ________________________

Previous job & employer ____

YOUR EDUCTIONAL INFORMATION

Highest grade finished: __________________ Year ______________ Degree: ________

If attended college, specify major (s) ____

YOUR HEALTH HISTORY

Primary Care Physician: ___________________________

Address: ____

Phone: ____________________

Are you experiencing now, or have you experienced in the past, significant health problems? Y N

Please list if any:
____

____

YOUR PREVIOUS COUNSELING HISTORY

Have you ever been treated by a psychiatrist, psychologist, licensed clinical social worker, or any other mental health worker? Y N

If yes, please specify:

Therapist's Name	Dates	Reasons	For How Long	Were You Satisfied?

Have you ever been hospitalized for psychiatric reasons? Y N

If yes, please explain:
____

____

MEMBERS OF YOUR FAMILY OF ORIGIN

Father's name: ____
If living, age: __________
If deceased, when and cause of death ____
Occupation ____

Mother name: ____
If living, age: __________
If deceased, when and cause of death ____
Occupation ____

Have your parents ever divorced? Y N
If yes, how old were you when they divorced? __________

Do you have any brothers or sisters? Y N
Please list them by order of birth:

Name	Age	Married?	Children (#)	Living?

YOUR SIGNIFICANT LOSSES

Please list any significant losses you have experienced throughout your life:

1. ___________________________________ 2. ______________________________
3. ___________________________________ 4. ______________________________
5. ___________________________________ 6. ______________________________
7. ___________________________________ 8. ______________________________
9. ___________________________________ 10. ______________________________
11. ___________________________________ 12.______________________________
13. ___________________________________ 14. ______________________________
15. ___________________________________ 16. _____________________________

YOUR MARITAL STATUS (at present)

Single __ Cohabiting __ Married __ Separated __ Divorced __ Widowed __
If you are married, for how long have you been married? _________________
If you have been married more than once, please specify how many times ______

YOUR CURRENT FAMILY

If in a relationship/marriage:

Your partner's name ____________________________ Age __________________

Phone #: Home ____________________ Cell: ___________________________

Occupation ____________________________________

Employer _____________________________________

Address: ______________________________________

Work Phone # :_________________________________

How long have you been together? ______________________________________

Do you have any children from this union? N Y

Name (First and last)	age/ date of birth	M / F	Living with you?

Do you have any children from other relationships?

Name (First and last)	age/ date of birth	M / F	Living with you?

OTHER CURRENT HOUSEHOLD MEMBERS

Name/Relationship	Date of Birth	Male/Female	Dependent? Y or N

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PARTY RESPONSIBLE FOR PAYMENT

Name: ______________________________ Relationship: ___________________________

Address: ____

City: _____________ State: _________ Zip: ______________ Phone: ____________________

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IN CASE OF EMERGENCY

Name: ______________________________ Relationship: ___________________________
Address: ____
City: _____________ State: _________ Zip: ______________ Phone: ____________________

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INSURANCE INFORMATION

Please note: If you have out of network benefits I will be happy to provide you with a monthly insurance claim to send it off to your insurance carrier, in order to be reimbursed.

Insurance Company ____

Member/Subscriber Number ____

Group Number: ____________________ Plan Number: __________________________

Authorization Number: ____

Number of Sessions Authorized: ________ Time Span Authorized: _________________

Number of sessions per year: ___________ Copayment: __________________________

For out of network benefits, what is your deductible: _____________________________

Insurance Phone Number: ____

Insurance Address: ____

IF INSURED IS DIFFEREENT FROM PATIENT, PLEASE COMPLETE THIS SECTION ALSO

Name of insured (if different than patient): ____________________________________

Social Security of member/subscriber: ____

Date of birth: ___________________ Employer: _______________________________

Relationship to patient: ____

SECONDARY INSURANCE INFORMATION, IF APPLICABLE

Insurance Company: _________________ Name of insured: ____________________

Phone Number: _____________________ Address: ____________________________

INFORMED CONSENT TO UTILIZE INSURANCE BENEFITS

Authorization for Release of Medical Information

Open communications between your psychotherapist and the primary physician is very important. It is also required by the insurance company in order to continue authorizing further treatment for you, if needed.

Please give your consent and authorization to release the necessary information to your primary physician.

I HEREBY AUTHORIZE MS. DITA TEITELBAUM, LCSW TO RELEASE RELEVANT MEDICAL INFORMATION TO MY PRIMARY PHYSICIAN.

____

Patient's Name (please print)

____________________________________ ______________

Patient's signature Date

____________________________________ ______________

Therapist's signature Date