Patient Information Form

Name: ____M F (circle one)
First Middle Last

Address:

____
City State Zip code

Home Phone # (______)__________________ Work Phone # (______)___________________

May I call you and leave messages at these numbers?

Yes No (circle one) Yes No (circle one)

____
Driver's License number

_____________________________ (______)________________________
Email Address (if applicable) Cell Phone (if applicable)

______/_______/_______ ___________ ______-_____-________
Birth date Age Social Security #

Relationship Status (circle as applies): Single Married Divorced Separated Domestic Partner Widowed

Please list people living in the household with you, and their relationship to you:

____

____

Are you a full-time student? Yes No (Circle One)

Employer: _________________________________ Occupation: __________________________

Family Physician: ______________________________Psychiatrist: __________________________

Name of Person Responsible for Payment: ___________________________________

____ (_____)______________
Address of responsible party (if different than above) Phone Number

Would you please let me know how you came in contact with me:
Referral source:
☐ Psychology Today website ☐ San Diego Therapists website ☐ GoodTherapy.org ☐ Google Search Page Ad ☐ Bing search ☐ Yahoo search ☐ referred by ______________________________

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Person you give permission for James A. Staunton, MFT to communicate with in the event of an emergency such as danger to self, danger to others, or severe psychological distress:

Contact Name: ____________________ Relationship to you: __________________

Phone: _____________________ Address: ____

Second Contact Name: _______________________ Relationship: ______________

Phone: _____________________ Address: ____

INSURANCE INFORMATION: ***Please be aware that you are ultimately responsible for paying for your therapy. If your insurance denies payment, or if you have an unmet deductible, you must pay for the sessions yourself. Please call your insurance carrier and find out what is allowed, what copay is involved, and what will be your responsibility.***

Do you have insurance? Yes No (circle one)

Primary Insurance Carrier: ____________________________ ID#: _______________________

Policy Holder: _____________________________ Group # _______________________

Address:____

Your Insurance Information Phone number (back of card): (______)-______-_________

Secondary Insurance Carrier: _____________________________________ ID# ____________________

Policy Holder: ___________________________ Group # ______________________

Insured SSN: ______-____-________ Insured Date of Birth: ___________________

Client's relationship to the insured: Self Spouse Dependent (Circle One)

Have you ever seen a therapist before? If so, please list year, provider name, and the issue for which treatment was sought:

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Please list any medication you are currently taking:

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