

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

Please let me know how you came in contact with me:

Referral source:

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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:

Please list any medication you are currently taking:

