PSYCHOLOGICAL HEALTH ASSOCIATES, PA
Patient Information Form

Patient Information

First Name: ________________ MI.: ____ Last Name: _________________
Address: ____
City: _________________________ State: _________________ Zip: ________
Referred by:_________________ Physician's Name:_______________________
Home Phone: (___) ___ - _____
Work Phone: (___) ___ - _____
E-mail: ________________________________
Date of Birth: _________________________
Sex: Male Female Marital Status:____________
Employment Status or School Grade: ___________________________
Parents' Names (for children) _________________________________
Patient Illnesses____
Patient Medication:
(if needed, continue on reverse)

Primary Insurance Company: ____________________________________
Subscriber or Policy Holder: _____________________________________
Policy ID#: ______________________
Soc Sec # of Insured (Value Options and CIGNA)________________
Subscriber's Date of Birth: _____________
Relation of Subscriber to patient: _________________________

Secondary Insurance:
Insurance Company: _________________________________
Subscriber or Policy Holder: _____________________________________
Policy ID#______________________________ Group#________________
Subscriber's Date of Birth: ______________________
Relation of subscriber to patient: ________________________________

(Initial as appropriate)
I authorize Psychological Health Associates, PA, to release information to my insurance company.
I authorize the payments of Medical Benefits to Psychological Health Associates, PA.
I authorize the release of information to my (or child's) physician

Signed____________________________ Date_____________
(Signature of Patient or Parent/ Guardian)