FOOTHILL PSYCHOLOGICAL ASSOCIATES

PATIENT INFORMATION

Please complete and sign where appropriate.

Section I - Identifying Information

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Pager # _____

Email Address _____

Date of Birth _____ Social Security Number _____

Marital Status _____ Gender ☐ Male ☐ Female

Employer or School _____ Employment Status/Grade _____

Referred By _____

Is the patient covered by insurance? ☐ Yes - Go to section II

☐ No - Go to section V

Section II - Insurance Information

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

If "Patient Relationship to insured" is other than "Self" please complete the following. If patient is the insured go directly to section III.

Insured's Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Pager # _____

Email Address _____

Date of Birth _____ Social Security Number _____

Marital Status _____ Gender ☐ Male ☐ Female

Employer or School _____ Employment Status/Grade _____

Section III - Insurance Policy Information

☐ Medicare ☐ Medicaid ☐ ChampUS ☐ ChampVA ☐ Group Health Plan ☐ FECA ☐ Other

Insurance Company _____

Address _____

Address _____

City _____ State _____ Zip _____

Plan Name _____

Policy Number _____ Group Number _____

Is the patient covered by more than one insurance? ☐ Yes - Please complete Section IV

☐ No – Go to PATIENT HEALTH HISTORY Page 3

Section IV - Secondary Insurance Policy Information

☐ Medicare ☐ Medicaid ☐ ChampUS ☐ ChampVA ☐ Group Health Plan ☐ FECA ☐ Other

Insurance Company _____

Address _____

Address _____

City _____ State _____ Zip _____

Plan Name _____

Policy Number _____ Group Number _____

Section V - Billing Information

(Complete only if there is no insurance coverage.)

Who is responsible for charges for this patient? ☐ Patient - Go to PATIENT HEALTH HISTORY Page 3

☐ Other - Please complete the following information

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Pager # _____

Email Address _____

Date of Birth _____ Social Security Number _____

Marital Status _____ Gender ☐ Male ☐ Female

Employer or School _____ Employment Status _____