Psychological
& Family
Consultants, Inc.

4572 Dressler Road N.W. • Canton, Ohio 44718 • Answering Service 330-493-4220 • Fax 330-493-8850

PATIENT INFORMATION:

Date:______________________

Last Name: ______________________________ First Name: ______________________ Middle Initial:____

Street Address:____

City:___________________________________ State:_________________ Zip: ____________________

Home Phone:____________________ Cell Phone:___________________ Work Phone: ________________

Date of Birth:_________________________ Age:_______________ Male Female

Social Security Number:____

Place of Employment: ___________________________________ Work Phone: _______________________

Employment Status: Full-time Part-time Retired Unemployed

Student Status: Full-time Part-time Not a Student

Marital Status: Single Married Separated Divorced Widowed

Name of Spouse/Partner (if applicable):____

If Minor, Mother's Name____

If Minor, Father's Name____

Please list the names and ages of your children. In case of minor patient, please list names and ages of siblings.

Name:___________________________Age:_____ Name:___________________________Age:_____

Name:___________________________Age:_____ Name:___________________________Age:_____

EMERGENCY CONTACT INFORMATION:

Name of Contact: _______________________________________ Relationship: ____________________

Home Phone:____________________ Work Phone:___________________ Cell Phone: ________________

REFERRAL INFORMATION:

How did you hear about us? ____

Referring Doctor: ____Phone #: ____________________

Primary Care Physician: _______________________________________ Phone #: ____________________

Have you previously received psychological care? Yes No

If yes, with whom? ____ Phone #: ____________________

PLEASE LIST THE CURRENT REASON FOR SEEKING HELP:

____

____

____

PRIMARY INSURANCE INFORMATION:

Name of Insured:__________ Relationship to Patient: __________

Address of Insured:__________

City:__________ State:__________ Zip: __________

Home Phone:__________ Cell Phone:__________ Work Phone: __________

Date of Birth:__________ Age:__________ Male Female

Social Security Number of Insured:__________

Place of Employment of Insured:__________

Address of Employer:__________

Phone Number of Employer:__________

Name of Insurance Company:__________

Address of Insurance Company (to submit claims):__________

City/State/Zip:__________

Phone Number of Insurance Company:__________

Policy Number:__________ Group Number:__________

Effective Date:__________ Copayment, if known:__________

SECONDARY INSURANCE INFORMATION:

Name of Insured:__________ Relationship to Patient: __________

Address of Insured:__________

City:__________ State:__________ Zip: __________

Home Phone:__________ Cell Phone:__________ Work Phone: __________

Date of Birth:__________ Age:__________ Male Female

Social Security Number of Insured:__________

Place of Employment of Insured:__________

Address of Employer:__________

Phone Number of Employer:__________

Name of Insurance Company:__________

Address of Insurance Company (to submit claims):__________

City/State/Zip:__________

Phone Number of Insurance Company:__________

Policy Number:__________ Group Number:__________

Effective Date:__________ Copayment, if known:__________