ANCERA PSYCHOLOGY ASSOCIATES

Alison Milburn, Ph.D.

Client Introduction (Please Print) **Today's Date**: ___/ ____/_____

Name: Last_____First_____MI____
Gender: (Please Check) Male____ Female___
Address: _____
City: _____**ST**: _____ **Zip**: _____
Home Phone: (_____)-_____-_____ **Work Phone**: (_____)-_____-_____
Cell Phone: (_____)-_____-_____
Email: _____

If we need to contact you about a scheduling change, which of the following would be acceptable? (Check all that apply)

_____Ok to call ALL
_____Call home
_____Call home, leave a message on machine
_____Call home, leave a message with person
_____Ok to call cell, leave message
_____Call work
_____Call work, leave message on voicemail
_____Call work, leave message with person

Birthdate: _____/_____/_____ **Age**: _____
Education: _____
Single: _____ **Married**: _____ **Other**: _____ **Social Security Number**: _____-_____-_____

Employer: _____ **Occupation**: _____
Address: _____
City: _____ **ST:** _____ **Zip**: _____

Spouse's Name: _____ **Birthdate**: _____/_____/_____ **Age**: _____
Social Security Number: _____-_____-_____
Spouse's Employer: _____

Personal Physician: _____ **Referred by**: _____

Nearest Relative not living with you: _____
Address: _____
City: _____ **ST**: _____ **Zip**: _____
Phone Number: (_____)-_____-_____

OVER

Emergency Contact:
Name: _____Phone Number: _____
Relationship to you: _____

Insurance Information-** (skip this section if no insurance is being filed)**

Primary Health Benefit Plan: _____
Insurance Company Claims Address: _____
City: _____ ST: _____ Zip: _____
In whose name is your insurance plan? _____
Member's DOB: ___/_____/_____
Member's Address: _____
City: _____ ST: _____ Zip: _____
Member's Social Security Number: _____-_____-_____
Insured's Employer: _____
Insurance Plan #: _____ Group Number _____ Ins. Coverage %:____

Is pre-certification required? _____ If required, how many visits have you pre-certified? _____

Secondary Health Benefit Plan: _____
Insurance Company Claims Address: _____
City: _____ST: _____ Zip: _____
In whose name is your insurance plan? _____
Member's DOB: ___/_____/_____
Member's Address: _____
City: _____ ST: _____ Zip: _____
Member's Social Security Number: ___-_____-_____
Insurance Plan #: _____ Group Name of #: _____ Ins. Coverage %:____

PLEASE BRING THIS FORM ALONG WITH YOUR OFFICE POLICIES FORM WITH YOU TO YOUR INITIAL APPOINTMENT. WE LOOK FORWARD TO MEETING WITH YOU!