ADULT BACKGROUND INFORMATION

Name: ____ Today's Date: ________________

Date of Birth:______________________ Age:___________

Address:____
Street City State Zip

Telephone: Cell____________________Work___________________Home____________________

Name of Employer: ____________________________ Occupation: ________________________

Social Security #________________________________ Married _____ Single _____ Divorced ___
Widowed _____ Separated ____ Other ____

Spouse/Partner's Name:____

Date of Birth: ________________________Age:____________

Address (if different from above):

Address____
Street City State Zip

Telephone: Home______________________________ Mobile: ______________________________

Name of Employer______________________________ Occupation: ___________________________

Social Security #____

Children's Names(s):	Age:	Name of Other Parent?	Lives with?
__________________________________	___________	________________	_________
__________________________________	___________	________________	_________
__________________________________	___________	________________	_________
__________________________________	___________	________________	_________

Level of Education: ______________________________Currently a student?____________________

Have you seen a psychologist before?____

How did you select our office?____

May we let your referral source know you have contacted us? ________________________________

Problem which is of concern to you: ____

Who is your primary care physician?____

May I contact him/her? Yes____ Telephone number_________________________ No___________

Person Responsible for Account: ____

Billing Address:____
Street City State Zip

CANCELLATION POLICY: if you need to reschedule or cancel an appointment, please call at least 24 hours in advance. If you miss a scheduled appointment, regular fees will be charged to you for that time. Sudden emergencies or illness can be discussed.

FINANCIAL RESPONSIBILITY STATEMENT: I understand that I am responsible for all of the charges incurred for services provided to me and/or my family. I agree to pay my account as services are provided unless other arrangements are made. If there is an outstanding balance on my account, I agree to pay it as soon as I am made aware of the amount owed.

____ ____________________________
Signature of person completing this form Date