

**LIST PSYCHOLOGICAL SERVICES, PLC**  
**PATIENT INFORMATION SHEET**

Date: \_\_\_\_\_ Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: M / F Marital Status: \_\_\_\_\_

Phone #: \_\_\_\_\_ Can we leave a message? Y / N Alt. Phone #: \_\_\_\_\_ Message? Y / N

Address: \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Have you ever applied for, or are you currently on disability? Y / N Occupation: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ City: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Hours: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Have you been a client here before?:  Yes  No

Ethnicity (optional): Caucasian African-American Hispanic Native American Asian-American Other

Name of Person Responsible for Account: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Parents' Names and Birthdates (if patient is minor)**

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

**Insurance Information**

**Primary Insurance:** \_\_\_\_\_ Holder's Contract #: \_\_\_\_\_

Holder's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Holder's Phone #: \_\_\_\_\_ Holder's Social Security Number: \_\_\_\_\_

Holder's Place of Employment: \_\_\_\_\_ Group# / Coverage Code: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Holder's Contract #: \_\_\_\_\_

Holder's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Holder's Phone #: \_\_\_\_\_ Holder's Social Security Number: \_\_\_\_\_

Holder's Place of Employment: \_\_\_\_\_ Group# / Coverage Code: \_\_\_\_\_

**Medicare Clients:**  65 or older **Disability Type:**  Long Term  Short Term  Permanent / Total

Is patient's condition related to:  Employment,  Auto Accident or  Other Accident? Please provide

date of accident / injury and State in which accident occurred: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

This signature is to be kept on file for one year. I understand if any services are rendered after that date this signature will be considered valid unless written objection is sent by myself to LIST PSYCHOLOGICAL SERVICES, PLC.

\*\*\*\*\* (OFFICE USE ONLY) \*\*\*\*\*

Diagnosis: \_\_\_\_\_ Therapist: \_\_\_\_\_