**SUSAN BARNGROVER, PHD., M.S., P.C.**

**PATIENT INFORMATION FORM**

Patient Name_____Martial status (circle one) S M D W

Address_____City_____State_____Zip_____

Social Security #_____Date of Birth_____Sex M_____F_____

Home Phone_____Cell Phone_____Emergency Phone_____

Employer_____Phone #:_____

Spouse Name_____Date of Birth_____SS#_____

**RESPONSIBLE PARTY (Person responsible for bill)**

Name_____Relationship to patient_____Date of birth_____

Address_____City_____State_____Zip_____

Social Security #_____Employer_____Phone_____

**MEDICAL INSURANCE INFORMATION**

Primary Type of Insurance_____ Policy holder_____DOB_____

Certificate/ID#_____Group#_____Medicare#_____

Secondary Type of Insurance_____Insured's Name_____DOB_____

Certificate/ID#_____Group#_____

I hereby authorize treatment for the above-named patient and consent to the release of medical information to my insurance to pay directly to Susan Barngrover, PhD., P.C. for any services rendered. I REALIZE I AM RESPONSIBLE FOR ALL FEES INCURRED FOR SERVICES RENDERED. If after 30 days an outstanding balance remains my credit or debit card will be charged for the entire balance.
16 digit Credit card #_____Exp. Date_____ 3digit code_____

_____

Patient signature Responsible Party Spouse/Parent/Guardian Signature Date

**PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE COMPLETELY:**

Name_____Age_____Date of Birth_____

Social Security #___Today's Date_____

1) What prompted you to seek mental health services?_____

_____

2) Have you been treated for this problem in the past?_____

3) Was the treatment helpful?_____

4) What do you hope to achieve as a result of treatment?_____

_____

5) What is your current medical condition? Height_____Weight_____

6) List previous illnesses:_____

7) List previous surgeries:_____

8) List all hospitalization dates:_____

9) List all medications you are currently taking:_____

10) Do you have allergies?_____If so, what are they?_____

11) Do you smoke?_____If so, how many cigarettes per day?_____

12) What is your usual alcohol intake?_____

13) Have you ever received treatment for drug/alcohol abuse?_____

14) Who is your primary care physician?_____Last visit date_____

Address_____Phone #_____

Are you seeing a psychiatrist?_____If so, list name_____

15) Do you want your primary care physician contacted? Yes_____No_____

16) If a student: Name of School_____

Phone number_____Grade level_____Teacher_____