**Julien Perille,Psy.D**

**Licensed Psychologist**

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| --- |
| DATE |

**PATIENT INFORMATION**

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| **Patient Information**  | **PRIMARY CARE PHYSICIAN** | **PATIENT NAME** (LAST, FIRST, MIDDLE) | **SOCIAL SECURITY NUMBER** |
| **DATE OF BIRTH** | SEX M F | MARITAL STATUS Single Widowed Married  Divorced | DIAGNOSIS (your clinician will fill this out ) | PREVIOUS NAME (if changed since last visit) |
| RELIGIOUS AFFILIATIONS (optional):  |
| **ADDRESS** | CITY, STATE, ZIP CODE |
| Can we contact you at the above address  Yes  No | If No please provide us alternate address: |
| **HOME TELEPHONE**( ) | E-MAIL (OPTIONAL) | FAX (OPTIONAL)( ) |
| Can we call your home phone? Yes No | Can we call your work number below?:  Yes  No | Can we call your cell phone number below? Yes  No  |
| EMPLOYER( ) | WORK TELEPHONE NUMBER( ) | **CELL PHONE**( ) |
| ADDRESS | CITY, STATE, ZIP CODE |
|  | Can we contact you at your work? Yes No  | OCCUPATION: |
|  | **HOW DID YOU HEAR ABOUT ME?**  **** drperillecounseling.com  Psychology Today White/Yellow pages  Physician referral  Other source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Guarantor Information****(if patient is a minor)** | RESPONSIBLE PARTY OR CUSTODIAL PARENT | SUBSCRIBER NAME (LAST, FIRST, MIDDLE) | SOCIAL SECURITY NUMBER |
| DATE OF BIRTH | SEXMF | RELATIONSHIP OF PATIENT TO SUBSCRIBER | HOME TELEPHONE NUMBER( )  |
| ADDRESS | CITY, STATE ZIP CODE |
| EMPLOYER | WORK TELEPHONE NUMBER( ) |
| ADDRESS | CITY, STATE, ZIP CODE |
| **Emergency****Contact** | EMERGENCY CONTACT NAME  | RELATIONSHIP |
| HOME TELEPHONE NUMBER | WORK TELEPHONE NUMBER |
| ( ) | ( ) |
| **Spouse or Other Parent****(if applicable** | NAME (FIRST, MIDDLE, LAST) | HOME TELEPHONE NUMBER( ) |
| ADDRESS (if different than patient) | CITY, STATE, ZIP CODE |
| EMPLOYER | WORK TELEPHONE NUMBER( ) |
| **INSURANCR** | **PRIMARY INSURANCE COMPANY NAME** | TELEPHONE NUMBER( ) |
| ADDRESS  | CITY, STATE, ZIP CODE |
| GROUP NUMBER | CERTIFICATE/POLICY NUMBER | EFFECTIVE DATE | RELATIONSHIP TO SUBSCRIBER (INSURED) |
| SUBSCRIBER’S NAME | SUBSCRIBER’S EMPLOYER |
| **SECONDARY INSURANCE COMPANY NAME**  | TELEPHONE NUMBER( ) |
| ADDRESS | CITY, STATE, ZIP CODE |
| GROUP NUMBER | CERTIFICATE/POLICY NUMBER | EFFECTIVE DATE | RELATIONSHIP TO SUBSCRIBER (INSURED) |
| SUBSCRIBER’S NAME | SUBSCRIBER’S EMPLOYER |
|  |

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional service rendered. I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I request that payment of authorized medical benefits, if any, be made to Psychological and Educational Services on my behalf for any unpaid services rendered by Psychological and Educational Services clinicians.

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Signature Date

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I authorize the release of medical information to the health plan indicated by the information requested by the health plan to determine the payment of medical benefits.

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Signature Date