

Scottsdale Psychological Associates
11000 N Scottsdale Road, Suite 163
Scottsdale, Arizona 85254

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H) _____ (W) _____ (Cell) _____

Where do you prefer to receive calls from our office? Home Work Cell

Age: _____ Marital Status: _____ Birthdate: _____

Employed Full-Time Student Social Security Number: _____

Sex: Male Female Highest level of school: _____

If Child: Father's Name: _____ Phone: (W) _____ (Cell) _____

Mother's Name: _____ Phone: (W) _____ (Cell) _____

Are the biological parents: Married Separated Divorced

If divorced, who has power of medical decision making?

Mother Father Joint

Name of person completing paperwork and relation: _____

Email Address: _____ Please provide your email address if you wish to be contacted occasionally regarding upcoming workshops or special events. Email is not to be used for communication with your therapist, nor will your email address be released to any third party.

Referral Source: _____

Primary Care Physician: _____ Phone: _____

We routinely communicate with Primary Care Physicians in an effort to provide appropriate treatment.

Do we have your permission to notify your doctor named above? Yes No

In case of emergency please notify: Name: _____

Phone: _____

Employer Information: (Father and Mother if minor)

Primary Insured: Employer Name: _____

Employer Address: _____

Spouse: Employer Name: _____

Employer Address: _____

Insurance Information:

Insurance Company Name: _____

Social Security Number of policy holder: _____

Member ID Number: _____ Group Number: _____

Is Medicare your Primary Insurance Secondary Insurance I do not have Medicare

*******PLEASE SIGN IN BOTH BOXES*******

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: _____

DATE: _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services.

SIGNED: _____