Naomi B. Rather, LCMHC

Patient Information

First Name _____ Middle Initial _____

Last Name _____ Gender: ___M ___F

Mailing Address _____ Email Address _____

City _____State ____ ZipCode _____

Home Phone ( ) _____ SSN: _____

Work Phone ( ) _____ Date of Birth _____

Cell/Other ( ) _____ Employer _____

Important: Where may I leave a message?

H ___ W___ C ___

Emergency Contact Info: _____

How were you referred to this office? _____

Person Responsible for Payment

First Name:_____ Middle Initial:____

Last Name: _____

Mailing Address_____

City: _____ State:___ Zip Code:_____

Home Phone: ( ) _____ Work Phone: ( ) _____

Signature of Responsible Party_____

Insurance Information (This section must be filled out completely in order to process your claims.)

Patient's ID #: _____ Insurance Company:_____

Subscriber's SSN: _____

Subscriber's Last Name:_____ First Name:_____

Patient Relationship to Subscriber: { } Self { } Spouse { } Child { } Other

Subscriber's Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Work Phone ( ) _____

Subscriber's Birth Date: _____ Subscriber's Employer _____

I hereby authorize Naomi B. Rather to release any billing information to "Party Responsible for Payment."

Patient's Signature: _____ Date: _____

Primary Care Physician

Name of Family Physician: _____

Street Address: _____

City: _____ State: ____ Zip Code: _____

Phone: ( ) _____ Date of Last Visit: _____

May I contact to coordinate care? _____yes _____no

Members of Household and their ages:

Brief Reason for seeking treatment:

Have you ever seen a psychotherapist or psychiatrist before? If so, please list name and dates of treatment:

Current Medications and Dosages:

Are you currently being treated for any medical illness? If yes, please describe:

_____
_____

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