John R. Paddock, Ph.D., ABPP, LLC

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NEW PATIENT INTAKE FORM

PLEASE PRINT IF HANDWRITING OR CLICK GRAY AREA TO TYPE

TODAY'S DATE:			
PATIENT NAME:		**PERSON RESPONSIBLE FOR PAYMENT*:**	☐**SAME** ***or***
STREET:		**BILLING ADDRESS: STREET:**	☐**SAME** ***or***
CITY/STATE/ZIP:		**CITY/STATE/ZIP:**	
HOME TELEPHONE:		**◄ Home messages OK? (check box)** ☐**YES** ☐**NO**	
CELL TELEPHONE:		**◄ Cell messages OK? (check box)** ☐**YES** ☐**NO**	
Patient BIRTH DATE:		**CLIENT SOCIAL SECURITY #:**	
MARITAL STATUS: **Please check box**	☐**SING** ☐**MAR** ☐**DIV** ☐**SEP** ☐**WID** ☐ **OTHER**	**EMAIL ADDRESS:**	

EMERGENCY CONTACT*:		**◄ RELATIONSHIP:**	
		◄ TELEPHONE:	

NOTE:
If filing for insurance reimbursement, please provide a copy of insurance card with this form. Thank you

*Please read the PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT attachment.

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