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Today's Date ________/________/________

PATIENT INFORMATION

____ ☐ Single ☐ Divorced ☐ Married ☐ Widowed
Last First Middle ☐ Other:__________

Is this your legal name? ☐ Yes ☐ No If no, what is your legal name?______________________________

Any Former Names: ______________________________________ Date of Birth:________ Age:__________

Gender Identity: _____________ Preferred Pronouns: _____________ Sexual Orientation: _____________

____
Street Address City State Zip code

Phone: ___________________________________ Insurance Provider: _________________________

Email: ___________________________________ Insurance ID# ______________________________

Occupation:______________________________ Employer:___________________________________

Birth Date: _______/_______/________________ Co-Pay: _______________

Policy Holder ________________________ Date of Birth _______________ Relationship to Patient ________

IN CASE OF EMERGENCY:
Name of Local Friend or Relative:____

Relationship to patient: ______________ Home/Work/Cell No. ________________________________

The above information is true to the best of my knowledge. I authorize any insurance benefits to be paid directly to the provider. I understand that I am financially responsible for any balances. I authorize Todd Anderson, PhD, LP and my insurance company to release any information required to process my claims.

X____
PATIENT/GUARDIAN SIGNATURE DATE