YORK PSYCHOLOGY, P.L.L.C. / JANINE S. YORK, PSY.D.

MICHAEL N. DIVAK, PH.D.

Date ____________________

First Name _______________________ MI ______ Last Name _________________________

Address _________________________ City ______________ State______ Zip ________

Telephone (Home) __________________________ (Work/Cell) _________________________

Email ____

______Please initial if permission is granted to email statements, bills, and/or other communication to above email address.

Birthdate _____/_____/_____ Age ______ Gender ___F ___M Race ______________

Marital Status: ______________________________________

Name of Spouse/Guardian ____________________________ Phone ___________________

Address ______________________ City _______________ State _______ Zip _______

EMERGENCY INFORMATION

In case of emergency, contact:
Name (1) __________________ Relationship ______________
Phone __________________ Work ____________________
Address ___________________ City _________________ State ____ Zip ____________

Name (2) __________________ Relationship __________
Phone ________________ Work __________________
Address ___________________ City _________________ State ____ Zip ____________

Physician ____ Phone ______________
Address ___________________ City _________________ State _____ Zip ___________

Psychiatrist ____ Phone ________________
Address ___________________ City _________________ State _____ Zip ____________

Other Physicians ______________________________________ Phone ____________________

Current Medications ____

Allergies ____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place/Location ____
Position ___________________________________
Phone _______________________ Hrs ___________

Spouse's Occupation: ____

<u>INSURANCE INFORMATION</u>

Insurance Policy Holder Name: ____
(*if different from client)*
Client's relationship to Subscriber:____Self____Spouse____Child____Other
DOB: _____________________________ SSN: ________-_________-____________

Primary Insurance________________________Phone_________________________
Contracr/ID#_____________________________Group/Acct.#___________________

Secondary Insurance______________________Phone_________________________
Contract/ID#_____________________________Group/Acct.#___________________
Subcriber________________________________DOB___________________________
Client's relationship to Subscriber:____Self____Spouse____Child____Other

<u>REFERRAL SOURCE</u>

How did you hear of York Psychology, P.L.L.C. (or from whom)?
____

Address _________________________ City __________________ State ______ Zip _______
Phone __________________________
Relationship to referral source ___________________________

Client Signature ____Date___________________

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