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

Patient Information:

Name: ____

Address: ____

City: ______________________ State: ____________ Zip Code: ____________

Phone: (H) ____________________ (W) ____________________ (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: ____________________________

Referral Source: ____

Primary Care Physician: ________________________________ Phone: ____________________

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: