**Pine Bush Mental Health, LLP**

1A Pine West Plaza

Albany, NY 12205

(518) 862-1665 FAX (518) 862-1668

|  |  |  |
| --- | --- | --- |
| **M. Katherine Kennedy, Ph.D.****Patricia P. Miller, Ph.D.****Rose J. Capurso, Ph.D.** | **Steven D. Kronick, M.D.****Edith H. Lundquist,N.P.P.****Rhonda Landis, Ph.D.** | **Timothy D. Landis, M.D****Karen L. Smith, N.P.P** |
|  |  |  |

 ***NEW PATIENT INFORMATION SHEET***

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CITY: STATE: \_\_\_\_\_ ZIP CODE: \_ \_**

**HOME PHONE:( ) WORK #:( ) CELL:( )\_\_\_\_\_\_\_**

## DATE OF BIRTH: \_\_\_\_SOCIAL SECURITY # \_

**Email Addres**s\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRING PHYSICIAN: \_ \_**

 ***INSURANCE INFORMATION***

**Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Member ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of policy holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy holder’s date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary insurance company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and date of birth of policy holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ***EMPLOYMENT INFORMATION***

**CONTACT PERSON/NEXT OF KIN PHONE #**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **EMPLOYER OCCUPATION**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***\*\*\*\*IF YOU HAVE SEEN ANOTHER MENTAL HEALTH PROVIDER\*\*\*\****

 ***THIS YEAR HOW MANY VISITS WERE USED?***

**I authorize the release of medical information necessary to process claims for medical benefits.**

**I authorize payment of medical benefits to Pine Bush Mental Health for services rendered.**

#### Signature of patient/guardian DATE

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**WITNESS**

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