Clear Creek Psychological Services 3501 NW Lowell, Ste. 201 Silverdale, WA 98383
(360) 698-8980 fax: (360) 698-8950

PATIENT INFORMATION: Date:_____

Name:_____ SS #:_____ Phone:_____
Address:_____
City: _____ State: _____ Zip:_____
Sex: M____F____Birthdate:_____Marital Status:_____
Emergency contact:_____Emer. Phone:_____
Occupation/Grade in school:_____
Business/School:_____Business Phone:_____
Referred By:_____
May I leave messages at your home or message phone? Yes__No___Msg. #_____

PRIMARY INSURANCE:

Person Responsible for Account:_____
Relation to Patient:_____Birthdate:_____SS#:_____
Address (if different):_____Phone:_____
City:_____State: _____Zip:_____
Person Responsible Employed by:_____Occupation:_____

Insurance Company:_____Subscriber #:_____Group#:_____

ADDITIONAL INSURANCE: yes no
Subscriber name_____Relation to Patient _____
Birthdate:_____SS# or Subscriber #:_____
Address (If different from patient's):_____
City:_____State: _____ Zip: _____
Phone:_____Business Phone:_____
Insurance Company:_____

ASSIGNMENT AND RELEASE
I, the undersigned, certify that I (or my dependent) have insurance coverage with: _____ and assign directly to _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor or provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I give my authorization for my therapist to provide me with back-up therapeutic assistance if s/he is ill, on vacation or otherwise unavailable, if necessary.

_____/_____/_____/_____
(Responsible Party Signature) (Relationship) (Minor Signature) (Date)

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Please answer the following questions regarding the patient listed.

Patient Name: _____
Patient's Primary Care Physician: _____ Phone: _____
Any Medications the Patient is currently taking; please note who prescribed them: _____
_____
_____
Past therapists the patient has worked with: _____
Hospitalizations for mental health reasons (If yes, when and where): _____
_____
Is the patient receiving medical care at this time? If so, who is the treating provider and what is being treated:
_____
_____

Any known history of the following experiences for the patient:
Suicidal Ideation or attempts: If Yes, detail: _____
Self-injurious behaviors: If Yes, detail: _____
Witness to or victim of Domestic Violence: : If Yes, detail: _____
Physical Abuse: : If Yes, detail: _____
Sexual Abuse: : If Yes, detail: _____
Neglect: : If Yes, detail: _____
Substance Abuse by patient or immediate/extended family member: _____
_____

Any known head injury where the patient was disoriented, lost consciousness or required hospitalization:
_____

Concern/problem that brought you to the office:
_____
_____
_____

What have you tried to address the concern/problem:
_____
_____
_____

What do hope to achieve from therapy and/or what are your goals in therapy:
_____
_____
_____