# Dill-Standiford Psychological Associates
## Patient Information Sheet

***Providing Comprehensive Mental Health Care***

Patient name: _____
First MI Last

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ SS number: _____

___Male ___ Female

___Single ___Married ___Separated ___Divorced ___Widowed

Home phone: _____ Work phone: _____

Guarantor/
Policy Holder: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SS number: _____

Home phone: _____ Work phone: _____

Primary insurance company: _____

Policyholder: _____

ID number: _____

Group no.: _____

Secondary insurance company: _____

Policyholder: _____

ID number: _____

Group no.: _____

Emergency Contact _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

FOR OFFICE USE

Deductible: _____

Patient Copay/
Coinsurance _____

Session
Limit _____

Precertification _____

Assigned Provider _____

Referring Provider _____

Provisional Diagnosis _____