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CONTACT INFORMATION

Last Name: _____ First Name: _____
Middle Initial: _____

Preferred pronouns:

_____ She/her/hers

_____ He/him/his

_____ They/them/theirs

_____ Other: _____

Date of Birth: _____ / _____ / _____

Home Address: _____
City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

E-mail: _____

Please check if the following are acceptable for communication and confidential messages:

_____ Home Phone

_____ Work Phone

_____ Cell Phone

_____ E-mail

Emergency Contact: _____

Relationship: _____

Emergency Contact Phone(s): _____

Referral Source: _____

Primary Care Physician: _____

Primary Care Physician Phone: _____ Last Visit: _____

Psychiatrist: _____

Psychiatrist Phone: _____ Last Visit: _____

Psychotherapist: _____

Psychotherapist Phone: _____ Last Visit: _____

Insurance: _____

Name of Insured: _____

Policy Number: _____

Employer: _____

Position: _____

Phone number: _____

Address: _____

To be used only in the event of missed appointment or payment:

Credit card # _____

Expiration Date _____ Security Code _____

Do you have Medicare? Yes / No

I understand that if I have Medicare and want to engage in treatment with Dr. Huberman, I will be expected to sign a private contract with Dr. Huberman, agreeing that I will not submit invoices to Medicare for reimbursement. This private contract can be found on the "Resources and Forms" page of Dr. Huberman's website.

Patient Signature

Date