

CAROL A. MUNSCHAUER, PH.D.

PSYCHOLOGIST – PSYCHOANALYST
(716) 835-8288

OFFICE ADDRESS:
605 LEBRUN ROAD
AMHERST, NEW YORK 14226

MAILING ADDRESS:
605 LEBRUN ROAD
AMHERST, NEW YORK 14226

PATIENT INFORMATION FORM

PERSONAL INFORMATION:

Name: _____ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
Phones: Home _____ Cell _____ Work _____
Email Address (*please print clearly*): _____
Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____
Who may we thank for referring you? _____
Is it permissible to you that we do? If so, sign here: _____
Who may we contact in an emergency? _____ Phone #: _____

EMPLOYMENT:

Employer: _____ Occupation: _____
Employer's Address: _____ City: _____ State _____ Zip _____

FAMILY MEMBERS:

Mother's Name: _____	Date of Birth: _____	Death? _____
Father's Name: _____	Date of Birth: _____	Death? _____
Siblings' Names: _____	Dates of Birth: _____	Death? _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Children's Names: _____	Dates of Birth: _____	Where do they reside? _____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EDUCATION:

Name of High School _____	Dates: _____
Name of College _____	Dates: _____
Names of Other Schools Attended: _____	Dates: _____
_____	_____
_____	_____
_____	_____

(OVER)

ATTENDING PHYSICIAN:

Primary Care Physician: _____ Date of Last Physical: _____
Do you have, or have you had, any medical problems or illnesses, Yes No
either now or in your childhood? If so, please explain:

Are you currently in treatment for any illness or medical problem? Yes No
If so, please explain:

Does anyone in your family have any medical illness currently? Yes No
If so, please explain:

Does anyone in your family have any past or present psychiatric illness? Please explain: Yes No

HEALTH INSURANCE INFORMATION:

*Although our office does not participate directly with any health insurance carriers, we are happy to complete forms for you and to assist you in receiving benefits you are entitled to according to your policy. You will need to give us **written** authorization to release this confidential information.*

Policyholder's Name: _____ Birth Date: _____
Policyholder's Employer: _____ Major Medical: Yes No

Primary Insurance Carrier: _____
Address: _____
Certificate or ID #: _____ Group: _____ Class: _____

Secondary Insurance Carrier: _____
Address: _____
Certificate or ID #: _____ Group: _____ Class: _____

I understand and agree that regardless of my insurance status I am responsible for the balance of my account for any professional services rendered. I have read all the information in this packet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature

Date

Parent's Signature (if minor)

Date