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 ______________