AURA R. DESCHAMPS, PSY.D.

Licensed Psychologist

psychotherapy & psychological evaluations for adults and children

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Patient Information

1. Patient Name: _____ **Sex:** M / F **Date of Birth:** _____ **Age:** ___

2. email: _____ **Home Phone#:** _____ **Mobile Phone#:** _____

3. Home Address: _____

4. City, State, Zip: _____

5. Family Physician/Pediatrician: _____

6. Place of employment: _____ **Occupation:** _____

7. Work Address: _____

8. Marital Status: _____ **Spouse's Name:** _____

9. Please list name , age, and relationship of individuals who live with person named on line #1:

	Name	Age	Relation		Name	Age	Relation
a.				d.			
b.				e.			
c.				f.			

10. Referral Source: _____

11. May I thank the physician or health care provider for referring you? (please initial) Yes ____ **No** ___

12. Reason for Making this Appointment: _____

Insurance Information

1. Name of Insurance Carrier:_____ ***(Please provide card to copy)***

2. Name of Policy Holder:_____ **Date of Birth:** _____

3. Policy ID.: _____ **Relationship to Patient:**_____

4. Insurance Company Phone #: _____

5. Employer Providing Insurance: _____ **Group #:**_____

6. Other Insurance: _____

(please complete page two if the patient is a child or adolescent)

Child/Adolescent Information

1. Name or School: _____ **City:** _____

2. Grade Level: _____ **Primary Teacher:** _____

3. Principal: _____ **School Counselor:** _____

Parent Information Section

4. Custodial Parent of Legal Guardian: _____

5. Address (if it differs from one previously listed): _____

6. Phone #'s (home): _____ **(work):** _____

7. Place of Employment: _____

8. Work Address: _____

9. Non-custodial Parent or Legal Guardian: _____

10. Address (if it differs from one previously listed): _____

11. Phone #'s (home): _____ **(work):** _____

12. Place of Employment: _____

13. Work Address: _____