CLIENT INFORMATION

Carol Pierce-Davis, Ph.D.
Psychologist

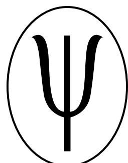
National Register of Health Service Providers

Texas Health Service Provider

Board Certified Diplomate Fellow Psychopharmacology

Board Certified Diplomate Fellow Serious Mental Illness

Board Certified Medical Psychologist



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Date ______________________

Referred by ____

PATIENT:
Name___________________________________Marital Status _______________

SS#_____________________Gender_______DOB_______________Age_________

Current Address ____

City, State, Zip____

Telephone (mob)________________Email Address___________________________

SPOUSE:
Name__________________________________DOB__________________________

SS#_________________________________Employer_________________________

PHYSCIAN_________________________Telephone_________________________

IN CASE OF EMERGENCY, NOTIFY___________________________________

Telephone _____________________________Relationship_____________________

INSURANCE INFORMATION

Name of Insurance Company____
(Be sure to provide doctor with Insurance card and drivers license, as well as pre-authorization number if needed)

Policy-holder's Name ______________________________DOB________________

Policy-holder's SS Number or Insurance ID Number___________________________

I authorize the release of information necessary to process my insurance claim.

Signature______________________________Date__________________________

I authorize insurance payments to the provider.
Signature____Date__________________

FOR OFFICE USE ONLY: INITIAL/PROVISIONAL DIAGNOSIS________________