BLACK DIAMOND
PSYCHOLOGICAL SERVICES

New Patient Intake Form

Registration Information

Name: _____ Date: ___/___/___
First M.I. Last

Address: _____
Street City State Zip Code

Phone: (___) ___-_____ Email: _____

DOB: ___/___/_____ SSN: ___-___-_____ Gender: _____

Insurance Information

Check box if insured is also patient ☐

Insured Name: _____ Insured DOB: ___/___/_____

Insured SSN: ___-___-_____ Relationship to Patient: _____

Insured Address: _____

Insurance Company: _____ Insurance Type: ☐ HMO ☐ PPO

Member ID Number: _____ Group Number: _____

Employer Name: _____

Presenting Problem

In the space below, briefly explain your primary reason for requesting mental health treatment.