The Medical Hypnosis & Counseling Center, P.C. | Sandi Y. Squicquero, M.Ed., LPC

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New Patient Information

Date of consultation _____

Patient Name _____ Date of Birth _____

Patient address _____

Home phone_____ Work phone _____

SSN (required if billing insurance, otherwise optional) _____

Employer _____

Emergency Contact _____ Phone _____

Primary Physician _____ Phone _____

Have you ever been hospitalized for psychiatric concerns _____ (YES OR NO) If yes, please explain:
_____
_____

Any current legal matters pending _____ (YES OR NO) If yes, then please explain : _____
_____

Referral source _____

Primary Insurance Company _____ Phone _____

Claim address _____

Insured _____ Insured employer _____

Policy ID _____ Group/claim number _____

Secondary Insurance Company _____ Phone _____

Claim address _____

Insured _____ Insured employer _____

Policy ID _____ Group/claim number _____

I understand that I am responsible for any professional services rendered. I authorize the release of information necessary to process my insurance claims for payment to be made to Sandi Squicquero. I agree to pay all co-payments, deductibles and any portion that my insurance will not pay. I verify that the above information is truthful to the best of my knowledge.

Signature _____ Date _____

Insurance Coverage and EAP Information (copays, % of deductibles, EAP, etc.)
_____
_____
_____
_____