Andrew M. Leeds, Ph.D.
1049 Fourth Street, Suite G
Santa Rosa, CA 95404
(707) 579-9457

New Patient Information

(Please print. Include all information that applies to you.)

Patient's Name: _____

Home Address: _____
(Street) (City / State) (Zip)

Home Phone: (_____)_____ ❑Ok to call ❑Do not call Cell Phone: (_____)_____ ❑Ok to call ❑Do not call

SS#_____ ____ _____ Age:_____ Birth Date: _____

Patient's Employer: _____

Employer Address_____ Work Phone: (_____)_____ ❑Ok to call ❑Do not call

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Spouse/Domestic Partner's Name: _____

Spouse/Domestic Partner's Employer: _____

Employer Address_____Work Phone: (_____)_____ ❑Ok to call ❑Do not call

Number of Children: ____ Number living with you: _____ Names & Ages: _____

Relative to be Contacted in an Emergency

Name: _____ Phone: (_____)_____

Referral Information

Name of Your Personal Physician: _____

Physician's Address: _____ Phone: (_____)_____

How were you referred to this office? _____

If Patient is a Minor, Please Complete the Following:

Responsible Parent's Name (s): _____ Phone: (_____)_____

Responsible Parent's Employer: _____
(Name and Address)

Revised 12/20/2012

Medical Information

Are you currently under a physician's care? No ❑ Yes ❑ If yes, please give details:

Name of physician (s)	Medical condition
_____	_____
_____	_____
_____	_____

Are you currently taking medication? No ❑ Yes ❑ If yes, please list type and names of medications:

_____

_____

_____

Previous Therapy: Are you now in or have you previously participated in individual, couple or group therapy? No ❑ Yes ❑ If yes, please explain:

Indiv Couple or Group	Length of treatment	Reason (s) for seeking therapy	Reason (s) for discontinuing	Year ended
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Financial Agreement and Treatment Authorization

I authorize treatment for (patient's name):_____and agree to pay all fees and charges at the time services are provided to me unless other arrangements are agreed to in writing in advance. Charges and services shown on insurance or billing statements are agreed to be correct and reasonable unless disputed by me in writing within thirty day of the original statement date.

By signing this agreement, I also agree to the Office Policies and Agreements on the attached sheet.

SIGN THIS AGREEMENT ONLY AFfER YOU HAVE RECEIVED A COPY, READ AND AGREED TO THE CONDITIONS DESCRIBED ON THE ATTACHED "OFFICE POLICIES AND AGREEMENTS" SHEET.

Name: _____
(print name of person accepting financial responsibility)

_____ _____
(signature) (date)

Insurance Information

If you have Medicare or a Victim of Crime Claim then request and complete the Insurance Information form. Also, please give us your Medicare or Insurance card to copy.

Revised 12/20/2012