Chesapeake Psychological Associates

(Please Print Clearly. The following information should pertain to the client.)

LAST NAME:_____FIRST NAME:_____MI:_____

DATE OF BIRTH:_____GENDER: Male_____Female_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL:_____

SOCIAL SECURITY #:_____EMAIL:_____

SPOUSE/PARENT'S NAME:_____

EMPLOYER:_____

PRIMARY INSURANCE COMPANY NAME:_____

POLICY #:_____GROUP #:_____

SUBSCRIBER NAME:_____SUBSCRIBER SS#:_____

SUBSCRIBER EMPLOYER:_____

SECONDARY INSURANCE CO NAME:_____

SUBSCRIBER NAME:_____SUBSCRIBER SS#:_____

POLICY #:_____GROUP #:_____

REASON FOR VISIT:_____

REFERRED BY:_____

Chesapeake Psychological Associates abides by the Privacy Practices that govern how your medical information may be used and disclosed. Please read the attached Notice of Privacy Practices to learn how your information may be used. You may keep the notice for your records.

I _____acknowledge that I have read the Notice of Privacy Practices regarding my right to privacy while receiving services in this office.

Signature:_____Date:_____

Parent or legal guardian signature if client is under the age of 18