Micah Altman, PsyD
Clinical Psychologist

PATIENT INFORMATION: Today's Date:_____

Name:_____ Date of Birth: _____

Address: _____ City: _____ Zip:_____

Home Phone: (___)_____Cell: (___)_____Work: (___)_____

Driver's Lic. #: _____

Employer: _____

SPOUSE/RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship to Patient: _____

Address: _____ Phone: (___)_____

Driver's Lic.: _____

Employer: _____

INSURANCE INFORMATION

Insurance Company: _____

Address: _____

Phone: _____ Plan or Group: _____

Insured's Name: _____ ID#: _____

Date of Birth: _____ Authorization #: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____

Address: _____

Phone: _____ Plan or Group: _____

Insured's Name: _____ ID#: _____

Date of Birth: _____ Authorization #: _____

REFERRED BY: _____