PSYCHOLOGY ASSOCIATES
OF LA MESA
5360 Jackson Drive, Ste. 104

(619) 698-9525
La Mesa, CA 91942

Patient Information Form

Name_____ Dr._____

Home Address_____
City zip

Phone_____ Cell_____ Date of Birth_____

Social Security #_____ Marital Status_____

CA Driver Lic.#_____ Referred by:_____

Occupation:_____ Employer_____

Work Address:_____

City:_____ Zip_____ Work Phone_____

Insurance Carrier:_____

Address of Carrier:_____

City_____ State_____ Zip_____

Phone:_____ Name of Insured _____

Insured's ID #_____ Group#_____

Patient is a Minor:
Parent or Guardian:_____CA Driver Lic.#_____

Address_____Phone_____

City_____ State_____ Zip_____

PERSON RESPONSIBLE FOR ACCOUNT_____

The undersigned accepts responsibility for the cost of all services rendered to the patient and attests that the information is true and correct. The undersigned further understands THAT APPOINTMENTS MUST BE CANCELLED ONE FULL BUSINESS DAY PRIOR TO THE SCHEDULED TIME OR BE CHARGED THE MINIMUM FEE OF $75.00.

Signed_____ Date_____