TERRAP ANXIETY AND PHOBIA CARE
COGNITIVE AND BEHAVORIAL HEALTH ASSOCIATES

A division of Julian M. Herskowitz, Ph.D, Psychologist, P.C.

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PATIENT INTAKE FORM

Patient name: ______________________ Date of birth: ______________

Patient address: ______________________ Male ☐ Female ☐

______________________ S.S #: ______________

Home #: ( ) __________ Work #: ( ) __________ Cell #: ( ) __________

Policy Holder's name: ______________________ Date of birth: ______________

Policy Holder's address: ______________________ S.S #: ______________

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Home #: ( ) __________ Work #: ( ) __________ Cell #: ( ) __________

Relation: ☐ Self ☐ Daughter ☐ Son ☐ Spouse ☐ Other __________

Is it Ok to contact you by email? ☐ yes ☐ No Email address: ______________________

Employer Name and Address: ______________________

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Primary Insurance Name: ______________________ Plan Name: ______________

Insurance ID #: ______________________ Group #: ______________

Tel. # (on back of card): ______________________

Address to mail claims (on back of card): ______________________

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Secondary Insurance Name: ______________________ Plan Name: ______________

Insurance ID #: ______________________ Group #: ______________

Tel. # (on back of card): ______________________

Address to mail claims (on back of card): ______________________

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Name of Primary Care Doctor	Name of Psychiatrist	Name of Gynecologist
Address	Address	Address
Phone #	Phone #	Phone #

Emergency contact name, relation and phone #:

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How were you referred to our practice? ______________________

Address and phone #: ______________________

For office use only:

Assigned Therapist Name: ______________________ **Diagnosis**: ______________

Location of Practice: ______________________