Jonibeth (J.B.) Whitney, Ph.D.

Clinical Psychology

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NEW CLIENT INFORMATION

Date: ___________________

Name: ______________________________ Age: _______ **Birth date:** ____________
Home Address: _________________________________
City / State: _____________________ **Zip:** ___________ **Phone:** _________________
Alt. phone: ________________
Employer: ____________________ Occupation: __________Work Title:___________
Education / Years in School: _________ Degree: _______ Field: _______________

Marital Status: (circle all that apply at present)
Single / Married / Divorced / Separated / Domestic Partner / Other

Partner's Name ________________________

Insurance Information (Aetna and Medicare only):
Medicare:
Medicare I.D. (Social Security No. & Alphabetic Letter):__________________________
Aetna:
Name of Insured (if other than patient): _________________________
Relationship to patient: ___________________
Insured's Birth date:_______________
Insured's Employer: ______________________________________
Aetna Policy or Group I.D. _________________________
Aetna Member I.D. ___________________________________

Emergency Contact Name: __________________________ Phone: _________________
Relationship to patient: ____________________________

I hereby give Dr. Whitney permission to contact this person in the event of an emergency

Please sign below to indicate that the information provided is true, complete and correct.

____

For Office Use:
ICD-10 Dx: __________________________________
Bill Insurance? __________________ Supplemental Insurance? _________
Co-Pay? _______________ Direct Pay? ______________
Send Invoice to: ____
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