Phyllis M. Richardson, Ph.D.
Licensed Psychologist

## GENERAL INFORMATION

Name: _____ Date: _____
Address: _____ Gender: _____ Age: _____
City: _____ State: _____ Zip: _____ Date of Birth: _____

Is it OK to send correspondence to this address? ___ Yes ___ No

How did you find out about me? _____

**Phone Numbers**: Please circle the "P" in front of your primary contact number.

P HOME: _____ OK to leave messages? ___Yes ___No
P WORK**:** _____ OK to leave messages? ___Yes ___No
P CELL: _____ OK to leave messages? ___Yes ___No

**Emergency Contact Information**
Name: _____
Phone: _____ Relationship to you: _____

**Significant Relationship Status**
___ Single ___Married ___Living as married ___Separated ___Divorced

___Widowed ___Non-traditional arrangement

Others living in the home: _____

**Employment**

Employer: _____ Position: _____
Length of time in this position: _____ Stress level of position: _____

**Insurance Information**
Primary insurance company: _____
Subscriber: _____ Subscriber's birthdate: _____
Employer: _____ Group # _____
ID # _____ Any other insurance? ___ Yes ___ No

**Primary Care Physician**
Name: _____ Phone: _____
Clinic name: _____ FAX: _____