Sarah Ray, Psy.D., QME
Advanced Health Care

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Welcome to ADVANCED HEALTH CARE

PATIENT: This section for the patient only: Date_____

Name_____ Gender Identification _____Age_____
Address_____ SS#_____ DOB ___/___/___
City_____ State ____Zip _____ Drivers License # _____
Employer_____ Marital Status M S D SEP W
Address_____ Spouse_____
City _____State_____ Zip_____ Preferred Phone #_____

Emergency Contact: _____
Address_____ Phone # _____
Signature (Please sign here if you authorize Dr. Sarah Ray and/or her associates to contact this person in the case of an emergency). _____

How did you hear about our practice? _____

RESPONSIBLE PARTY FOR BILL if other than patient:

Name_____ Relationship to patient _____
Address_____ Employer_____
City _____State_____ Zip_____ Address_____
SS#_____ DOB ____/____/____ City_____ State ____Zip_____
Home phone # _____ Work phone #_____

Please Check One: Private Insurance ( ) Cash ( ) Other ( )

PRIMARY Insurance Carrier

Company_____
Address_____
City _____State_____ Zip_____
Phone # _____
INSURED _____
(name on insurance card)
Insured's Relationship to Patient:
Self ( ) Spouse ( ) Child ( ) Other ( )
MEMBER ID# _____
Primary Member DOB:

SECONDARY Insurance Carrier

Company _____
Address_____
City_____ State ____Zip_____
Phone #_____
INSURED_____
(name on insurance card)
Insured's Relationship to Patient
Self ( ) Spouse ( ) Child ( ) Other( )
MEMBER ID#
Primary Member DOB:

Authorization to pay benefits to provider: I hereby authorize payment direct to Advanced Health Care of the Insurance benefits otherwise payable to me, and authorize release of information necessary to process a claim with my insurance company. I hereby accept responsibility for any charges not covered by my insurance, and for missed appointments or cancellations with less than 24-hour notice. A copy of this signature is valid as the original. Please also see informed consent document.

Signature _____ Date _____

(If a minor, guardian must sign above and the minor must sign as well providing assent to treat):_____

PROBLEM CHECK LIST

Below is a list of troublesome problems which may people often face. Read each one and place a (√) before those items of concern to you. Place two (√ √) before those items which are of the **most** concern to you.

___ Slow in getting acquainted with people
___ Feelings of worthlessness
___ Physical health complaints
___ Feeling tired much of the time
___ Concerned about physical or sexual abuse
___ Being Picked on or Bullied
___ Sometimes bothered by thoughts of insanity
___ Trouble falling asleep
___ Feeling inferior
___ Being watched or talked about by others
___ Thoughts of suicide
___ Not knowing what I really want
___ Poor appetite
___ Trouble in keeping a conversation going
___ Awakening in the early morning
___ Depressed "down in the dumps"
___ Concerned about my alcohol use
___ Wanting love and affection
___ Having feelings of extreme loneliness
___ Nervousness, or finding it difficult to relax
___ Not knowing where I belong in the world
___ Finding things to do in my spare time
___ Spells of terror or panic
___ Concerned about my drug use

____ The idea that something is wrong with my mind
____ Trouble controlling my temper
____ Lacking self-control
____ Marital Problem
____ Not reaching goals I've set for myself
____ Sexual problems
____ Boredom
____ Too little social life
____ Feelings of guilt
____ Concerns around food/Eating disorder
____ Wondering if I'll find a suitable mate
____ Being ill-at-ease with other people
____ Legal problems
____ Trouble concentrating
____ Can't forget some mistake I've made
____ Dissatisfied with current job
____ Afraid I might hurt someone
____ Difficulties in raising my children
____ Being timid or shy
____ Financial problems
____ Difficulty remembering things as I once could
____ Hearing voices that other people do not hear

Please tell us about any other special problems or issues that you would like to discuss**:**

Name _____ Date _____