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**PATIENT DATA:**

**INFORMATION:**

Last Name of Patient: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Ext. \_\_\_\_\_  
Mobile Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

**If patient is an adult:**

Patient Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Spouse's DOB.: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_

**If patient is a dependent under 25?**

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher/Guidance Counselor \_\_\_\_\_  
Name of Mother: \_\_\_\_\_ Mother's D.O.B.: \_\_\_\_\_  
Name of Father: \_\_\_\_\_ Father's D.O.B.: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel. No.: \_\_\_\_\_

**INSURANCE INFORMATION:**

**Primary Insurance Company Name:** \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's S.S.# \_\_\_\_\_  
Employer: \_\_\_\_\_ Patient Relationship to Insured: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Effective Date: \_\_\_\_\_ Deductible: \_\_\_\_\_  
COBRA Benefit? \_\_\_\_\_ Primary or Secondary: \_\_\_\_\_

**Secondary or Spouse's Insurance Company Name:** \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_  
Employer: \_\_\_\_\_ Patient Relationship to Insured: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group No.: \_\_\_\_\_  
Effective Date: \_\_\_\_\_ Deductible: \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ Office No.: \_\_\_\_\_

Address: \_\_\_\_\_

**Prior Treatment (use other side if needed):**

Psychiatric Out-Patient? Y / N Date(s): \_\_\_\_\_ Inpatient? Y / N Date: \_\_\_\_\_  
Name(s) /Address of Therapist(s) \_\_\_\_\_

Substance Abuse Inpatient? Y / N Date: \_\_\_\_\_ Out-Patient? Y / N Date: \_\_\_\_\_

If hospitalized, Name(s) of Facilities: \_\_\_\_\_

**REASON FOR APPOINTMENT (Please Check All That Apply):**

___ Alcohol	___ Drugs	___ Panic Attack	___ Sexual Abuse
___ Anxiety	___ Eating Disorder	___ Physical Abuse	___ Stress Reaction
___ Behavior Problem	___ Family Issues	___ Problem at Work	___ Suicidal Thoughts
___ Depression	___ Marital Issues	___ School Problems	___ Other (describe)

***Is your treatment:***

Required by a judge, the police or a probation/parole officer to have this appointment? Y / N  
Related to an accident/injury? Y/N If yes, is it: automobile? \_\_\_ Work related? \_\_\_ Related to a legal claim? \_\_\_