

Orange County Health & Psychology Associates
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Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

DOB: _____ Age: _____ SS#: _____

Driver's License #: _____ Marital Status: _____ Gender: _____ Ethnicity: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Spouse, Parents or Guardian Address: _____

Emergency Contact (name & telephone): _____

Reason for Visit: _____

Have you been hospitalized? _____ If so, reason: _____

Prior medical and surgical diagnosis: (Do you have a history of the following?) _____

Allergies: _____ If so, describe reaction(s): _____

Current medications: _____

Primary Insurance Company: _____ Phone No: _____

Identification No: _____ Group No: _____

Name of Insured: _____ Relationship: _____ DOB: _____

Secondary Insurance Company: _____ Phone No: _____

Identification No: _____ Group No: _____

Name of Insured: _____ Relationship: _____ DOB: _____

Please sign and date below to indicate that you have received a copy of the **NOTICE OF PRIVACY PRACTICES**.
Your signature simply acknowledges that you received a copy of this notice.

Name: _____ Signature: _____ Date: _____