Cate Richardson-Henley, LCSW-R
P.O. Box 36, Milford, NY 13807
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Fax: (607) 441-3091

New Patient Information

Date_____

Name _____ Date of Birth_____

Mailing address_____ City/State/Zip_____

Best Contact #_____ Alternate contact#_____

Email_____

If our office can leave a message on the above numbers, eg. To confirm an appointment, please indicate by signing below.

Name:_____

Prescribing Provider (if receiving psychiatric meds):
Name_____ Contact #_____
Fax #_____

Insurance Information: Name of Company _____
ID #_____ Group Number_____
Name of the Insurance Policy Holder _____
If you are not the policy holder, please fill-in the following:
D.O.B. Of policy holder:_____
Relationship to Policy Holder:_____ Address of Policy Holder: _____

_____

Secondary Insurance Information: Name of company_____ ID #_____ Group # _____ Name of Policy Holder_____ If not the policy holder, please fill-in the following information:
D.O.B. Of policy holder_____ Relationship to policy holder_____
Address of policy holder_____