Old Town Professional Psychology, LLC
Sundar J. Cook, Psy.D
411 ½ North Washington Street
Alexandria, VA 22314
(571) 327-0194

**(Please Print)**

**Today's Date** ____/____/____

## CLIENT INFORMATION

| Client's Last Name | First | Middle | ☐ Mr. ☐ Ms. | Marital Status (Circle One) Single / Married / Divorced / other |
|---|---|---|---|---|

| Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | (Former Name) | Birth Date / / | Age | Sex ☐ M ☐ F |
|---|---|---|---|---|---|

| Street Address | City | State | ZIP Code | Social Security - - | Home Phone No. ( ) |
|---|---|---|---|---|---|

| P.O. Box | City | State | ZIP Code | Cell Phone No. ( ) |
|---|---|---|---|---|

| Occupation | Employer | Work Phone No. ( ) |
|---|---|---|

Referred to Provider by (Please check one box & list) ☐ Dr. _____ ☐ Insurance Plan ☐ Website

☐ Family ☐ Friend ☐ Close to Home/Work ☐ Yellow Pages ☐ Other _____

| Email Address: | Alternative Email Address: |
|---|---|

## INSURANCE INFORMATION

| Person Responsible for Bill | Birth Date / / | Address (if different) | Home Phone No. ( ) |
|---|---|---|---|
| Email Address: | | | Cell Phone No. ( ) |

| Occupation | Employer | Employer Address | Work Phone No. ( ) |
|---|---|---|---|

| Is this client covered by insurance? ☐ Yes ☐ No | Is this an EAP visit? ☐ Yes ☐ No | Total Annual EAPs allowed? _____ |
|---|---|---|

What is exact name of insurance?

What is the authorization number? ☐ Self Pay

| Insured's Name | Insured's S.S. # | Birth Date / / | Group # | Policy # | Co-Payment $ |
|---|---|---|---|---|---|

Client's Relationship to ☐ Self ☐ Spouse ☐ Child ☐ Other _____

| Name of Secondary Insurance (if | Insured's Name | Group # | Policy # |
|---|---|---|---|

Client's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

## IN CASE OF EMERGENCY

| Name of Local Friend or Relative (not living at same address) | Relationship to Client | Home Phone No. | Work Phone No. |
|---|---|---|---|
| | | | |
| | | | |