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CLIENT INFORMATION

Date _____ **Referred by** _____

PATIENT:

Name _____ Marital Status _____

SS# _____ Sex _____ DOB _____ Age _____

Current Address _____

City, State, Zip _____

Telephone (h) _____ (w) _____ (mob) _____

Email Address _____ Employer _____

SPOUSE:

Name _____ DOB _____

SS# _____ Employer _____

PHYSICIAN _____ Telephone _____

IN CASE OF EMERGENCY, NOTIFY _____

Telephone _____ Relationship _____

INSURANCE INFORMATION

Name of Insurance Company _____

Policy # _____ Group # _____

Policy-holder's Name _____ DOB _____

Policy-holder's SS Number or Insurance ID Number _____

I authorize the release of clinical or other information necessary to process my insurance claim.

Signature _____ Date _____

I authorize insurance payments to the provider.

Signature _____ Date _____

FOR OFFICE USE ONLY: INITIAL/PROVISIONAL DIAGNOSIS _____