



# JEFFERSON NEUROBEHAVIORAL GROUP

CLINICAL PSYCHOLOGY • NEUROPSYCHOLOGY • BEHAVIORAL MEDICINE  
RESEARCH - ASSESSMENT - INTERVENTION - FORENSIC CONSULTATION - REHABILITATION

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

## **Welcome**

Welcome to Jefferson Neurobehavioral Group!

This is your New Patient Information Packet. Please fill out the packet entirely and bring it with you to your first appointment. We ask that you arrive at least ten minutes before your appointment and please bring your insurance card with you to the appointment.

Please note our cancellation policy: we require 24 hours notice of any appointment cancellation. If the initial appointment is cancelled less than 24 hours before the appointment, we will be unable to reschedule any future appointments with you in our office.

We look forward to meeting you. Please feel free to contact us with any questions you may have during office hours or leave a message after hours:

Thank you,

Jefferson Neurobehavioral Group



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Patient Name \_\_\_\_\_

Date \_\_\_\_\_

## Patient Information

Name (*First, Middle, Last*) \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ [ ] Male [ ] Female How long have you lived here? \_\_\_\_\_

Home Phone \_\_\_\_\_ May we call you at home? [ ] Yes [ ] No

Work Phone \_\_\_\_\_ May we call you at work? [ ] Yes [ ] No

Cell Phone \_\_\_\_\_ May we call your cell phone? [ ] Yes [ ] No

What phone number would you like us to call for a reminder call? \_\_\_\_\_

Occupation \_\_\_\_\_ How long at this occupation? \_\_\_\_\_

How long at present job? \_\_\_\_\_ Employed by \_\_\_\_\_

Birthplace \_\_\_\_\_ Religion \_\_\_\_\_

Military Service \_\_\_\_\_ Highest grade completed in school \_\_\_\_\_

Marital Status [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed [ ] Other

If you were married previously, give date: \_\_\_\_\_

Who referred you? \_\_\_\_\_

Who is your Primary Care Provider or other physicians to coordinate care with? \_\_\_\_\_

May we provide them with information about your visit? [ ] Yes [ ] No

### If patient is a minor:

Mother's Name \_\_\_\_\_ Address \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Mother's Contact Number \_\_\_\_\_ Mother's Work Phone \_\_\_\_\_

Mother's SSN \_\_\_\_\_ Mother's Date of Birth \_\_\_\_\_

Father's Name \_\_\_\_\_ Address \_\_\_\_\_

Father's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Father's Contact Number \_\_\_\_\_ Father's Work Phone \_\_\_\_\_

Father's SSN \_\_\_\_\_ Father's Date of Birth \_\_\_\_\_

If parents have different addresses, who is responsible for the bill? \_\_\_\_\_

**Reminder: Please come to your first appointment 15 minutes early.**

Your appointment is on \_\_\_\_\_ at \_\_\_\_\_ am/pm

Provider \_\_\_\_\_