Virginia Reid, Ph.D., Clinical Psychologist

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Phone: (513) 284-1021
Fax: (513) 487-3765
Email: email@drvreid.com

Name: _____ DOB: _____ Age: _____

SS #: _____ Gender: _____ Partner Status: _____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

May I contact you at home? May I contact you at work? _____

Can a message be left at these locations? Do you have any preferences on how you are to be contacted?
_____
(provide as much detail as necessary)

Employer or School:

Length of employment or grade in school:

Referred by:

Primary Care Physician: _____ Phone: _____

Do you want me to contact your physician (or other health provider) about your visit today?

Emergency Contact: _____ Phone: _____
(Name & Relationship)

Reason for seeking services:

List all current Medications:

Dates of past psychological treatment:

Insurance Company: _____ ID# _____

Group #: _____ Plan #: _____ Employer of card holder: _____

Group Name (if applicable):

Card Holder name: _____ Card Holder SS#: _____ DOB: _____

Authorization Number:

Who is responsible for payment of services?

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

Should bills go to the above address? _____

** It is important to understand the benefits that your insurance company offers for mental health claims. Often, the coverage differs from medical coverage. It is your responsibility to understand your benefits and to call for authorization of services.

Signature of Patient: _____ Date: _____

Signature of person financially responsible: _____ Date: _____

Print Name: _____