## Confidential New Adult Patient Information

Revel Miller, Ph.D.

Please answer all questions as completely as possible. If a question does not apply to you, simply leave it blank. Please print or write clearly. Thank you!

Personal Information				
Name:	Date of Birth:	Age:	Gender: M or F	
Place of Birth:				
Home Address:				
Preferred Mailing Address:				
Phones that we are permitted to co	all and leave messages at: H			
Email Address that we are permit	ted to use:			
Marital Status: □ Married □ Co-l	Habitating □ Single □ Separ	rated   Divorce	ed 🗆 Widowed	
Name of Spouse/Significant Othe	r: Number	& Age of Childre	en:	
Employer:	Occupation:			
Emergency Contact:	Relationship:	Phone:_		
Highest Level of Education Comp	leted:			
Physical Health:   Excellent   G	Good □ Fair □ Poor			
Current or Chronic Health Probler	ns:			
Current Medications & Dosages:_				
Primary Medical Doctor:	Date of L	Date of Last Exam:		
Referred By:	May I thank then	m for your referi	al? □ Yes □ No	
Previous Psychotherapy				
1. Therapist	City:	Dates:	to	
2. Therapist	City:	Dates:_	to	
Brief Description of Proble	m			
			roolo?	
Why you are seeking help now? V	vnat are your current problem	is, concerns or (	joais?	

Type of Psychotherapy I am seeking:   Type of Consultation I am seeking:   Pa	•	
Estimate severity of the problem(s) prese	ented:   Mild   Moderate   S	Serious   Severe
Any serious suicidal or homicidal ideas, p	plans or actions in the past 30	days? □ No □ Yes
Describe your personal strengths/talents/	/hobbies:	
Estimate your motivation to change:   Lit	tle 🗆 Moderate 🗆 Serious 🗈	 ∃ Highly Motivated
<b>Health Insurance Information</b>		
As a licensed psychologist, I am <u>not</u> a se <u>not</u> accept payment from health insurance send claims to your provider, we will do s receive a reimbursement check directly from	e providers. However, if you go so on a monthly basis. Then the	rant me permission to e policy holder may
Insured Person's Name/Policy Holder:	Tele	phone #:
Relationship to Patient:		
Insured's Mailing Address:		
Insurance Company Name:	ID Number:	Group#:
Telephone #: Claims Addre	ess:	
Four Agreements		
<ol> <li>Payment: I hereby agree to pay D</li> <li>Insurance: I give Dr. Revel Miller my insurance claims with my healt</li> <li>Consent for Treatment: I authorize psychological assessments, treatment understand that these procedures</li> <li>This Information Form: I have reagreements contained in this Conference</li> </ol>	permission to release informath insurance provider. ze and request Dr. Revel Mille nents and/or diagnostic proced will be explained to me and sured and fully understand all the	tion required to process r to carry out dures as his patient. I ubject to my agreement above information and
		//
Patient's Printed Name  PLEASE NOTE: Refer to Dr. Miller's Po	Patient Signature  olicies and Procedures Agre	Date ement for more in-
double datable alequit confidentiality are	antiana traatmant presses	9 mlannina ina

depth details about confidentiality exceptions, treatment process & planning, insurance, communications, fees, payment, missed appointments, patient rights, etc.

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