Carol Fahy Ph. D., Psy. D.

808-838-9541
CarolFahy.com

PATIENT INFORMATION SHEET

Please provide a copy of both sides of your insurance card(s) and driver's license, and complete the requested information below:

PATIENT NAME:							EMAIL ADDRESS:				
PHYSICAL ADDRESS:							PHONE NUMBERS:				
							Mobile Phone:				
	City		State		Zip		Home Phone:				
MAILING ADDRESS: (If different)							Work Phone:				
							OKAY TO TEXT?	Yes		No	
	City		State		Zip		OKAY TO EMAIL?	Yes		No	
BIRTHDATE: (mo/day/year)							SEX:	Male		Female	
SOCIAL SECURITY #:								OTHER (describe):			
IS PATIENT'S CONDITION RELATED TO:											
Employment:		Yes		No			STATUS:	Single			
Auto Accident:		Yes		No				Married			
Other Accident:		Yes		No				Living Together			
								Other			

FOR OFFICE USE ONLY:

Patient ID#: CF#: DX: Date First Seen:

PRIMARY INSURANCE COMPANY:						
FULL NAME OF INSURED: (If not patient)						
PATIENT RELATIONSHIP TO INSURED:	Self		Spouse		Child	
	Other (Please specify):					
INSURED'S ID #:						
INSURED'S POLICY GROUP OR FECA #:						
INSURED'S DATE OF BIRTH: (mo/day/year)						
EMPLOYER'S NAME:						
INSURANCE PLAN NAME:						
DOES THIS PATIENT HAVE ANOTHER HEALTH BENEFIT PLAN?	Yes (If yes, complete additional info)		No			
PRIMARY INSURANCE COMPANY:						
FULL NAME OF INSURED: (If not patient)						
PATIENT RELATIONSHIP TO INSURED:	Self		Spouse		Child	
	Other (Please specify):					
INSURED'S ID #:						
INSURED'S POLICY GROUP OF FECA #:						
INSURED'S DATE OF BIRTH: (mo/day/year)						
EMPLOYER'S NAME:						
INSURANCE PLAN NAME:						