

Psychological Services, LLC
Ebony Dennis, PsyD

Date of Birth: _____

Patient Name (First, Middle, Last):

Address on File with Insurance Company:

Email Address we are Authorized to Use for Correspondence and Billing:

Contact Phone Numbers (i.e., home, work, cell, others, where may I leave a voice mail message?):

Emergency Contact (please do not name anyone whom you would not be comfortable with me contacting should an emergency arise):

Name: _____ **Phone:** _____

Relationship: _____

Current Medications:

Have you ever received psychological or psychiatric treatment? If so, please describe [i.e., psychotherapy (how many courses?), medications (which?), hospitalizations (how many times?)]:
