Penelope J. Hooks M.D.
Patient Information Sheet
(Please Print)

Patient Name:_____ **Sex**_____ **Date of Birth**:_____

Parent/ Guardian Name: _____

Patient's S.S.#: _____**Marital Status** _____**Email** _____

Home Address: _____ _____ _____
Street **City/ State** **Zip**

Phone Numbers: _____ _____ _____
Home **Cell** **Spouse**

Work Phone _____**May we call you at work?** ____**Drug allergies**_____

Pharmacy _____**Phone**_____

Person responsible for Payment (if not above _____ _____**Phone**_____
Employer: _____

Employer's Address: _____ _____ _____
Street **City/State** **Zip**

Who referred you to this office: _____Phone____ _____
Search words used_____

Nearest friend / relative: _____ _____
(Not living with Patient): **Relation to Patient**

Address: _____ _____ _____ _____
Street **City/State** **Zip** **Phone Number**

This office does not have any agreements with insurance companies or other third party payers. Billing Statements are mailed on a monthly basis. If you need to have codes for diagnosis and procedures for insurance purposes, please indicate here_____

********PLEASE SIGN APPLICABLE SECTION BELOW********

By signing below I understand that payment for psychotherapy is due at the time of the visit. Also, cancellation of an appointment must be received by the end of the prior working day i.e. to cancel an appt. on Monday you must cancel by the end of the working day on Friday.

_____ _____
Patient's Signature **Date**

By signing below I understand that payment for psychoanalysis is due by the first of every month. Also, that I am responsible for payment for all missed sessions unless canceled by the analyst.

_____ _____
Patient's Signature **Date**