Stacie B. Isenberg, Psy.D., PLLC
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Patient Information -- Adult

Patient Name _____ Date _____

Date of Birth _____ Age _____

Address _____

City_____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

I consent to messages being left at: Home ☐ Cell ☐ Work ☐

Email Address* _____

**By providing my email address I am giving Stacie B. Isenberg, Psy.D., PLLC permission to contact me via this email address. I understand that email cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or be incomplete, or contain viruses. I understand that Stacie B. Isenberg, Psy.D., PLLC does not accept liability for any errors or omissions which may arise as a result of email transmission.*

If there are any special instructions for Dr. Isenberg when leaving messages at any of the approved phone numbers or when communicating via the email address, please specify here:

_____

_____

_____

Patient-Authorized Emergency* Contact: _____
*To be used if immediate, serious concern about the patient's health or the safety of patient /others

Relationship to Patient _____ Telephone _____

Address (if different from patient's)_____

Are you covered by Medicare, Medicaid, or Tricare? _____
(Please note that I do not accept any third party payment and have opted out of these plans. Any patient with these plans understands that they cannot be used).

Who referred you to Dr. Isenberg? _____

_____ _____
Signature Date