Julia J. Tate, JD, LCSW
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Patient Information

Patient's Name: ____

Home Address:____ Zip Code: ______________

Mailing Address (if different):____

____ Zip Code: ______________

Home Phone:______________ May we leave a message for you at this number? YES NO

Work/Cell Phone: ___________ May we leave a message for you at this number? YES NO

Patient's Date of Birth: _____/_____/______ Gender: F M SSN: _____-_____-_____

Patient's Relationship to Insured: Self ☐ Spouse or Partner of Insured ☐ Child of Insured ☐ Other☐

Patient's Status: Single ☐ Married ☐ Other ☐

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

Employer: __________________________ Employer's Phone Number: ___________________

Primary Care Physician (PCP) or Psychiatrist: ____

Phone Number and Address of Physician or Psychiatrist: ____________________________________

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Primary Insurance: _______________________________ Insured's ID #: __________________

Name of Insured: ____

Insured's Address: ____

Insured's Policy Group or FECA #: ____

Insured's Date of Birth: ____/____/____ Gender: F M Insured's SSN: _____-_____-_____

Insurance Phone #: (____)______________ Pre-Authorization #: _____________________

In completing and signing this information sheet, I (the patient or the patient's parent or guardian) am authorizing Julia J. Tate, LCSW, and the doctor named above as my Primary Care Physician or as my Psychiatrist to communicate fully with one another and to provide one another with copies of any and all of my medical records as such records are needed for diagnosis and treatment purposes. This release of medical records shall expire one year from the date I signed it. I know I can revoke this release by telling either Julia Tate or my physician or psychiatrist, in writing or by word of mouth, that I am do not want them to communicate any further. A copy of this release shall be considered as valid as the original.

Date: ____________ Signature of Patient or Patient's Parent: ______________________________