Insight Psychological Group
David Helfgott, Psy.D. LLC
773 Central Avenue, Westfield, NJ 07090
241 Cedar Lane, Teaneck, NJ 07666

Tax ID: 46-5382812
26-3073176
NPI: 1598184780
Main Office: 908-228-2740

NEW PATIENT INFORMATION SHEET

DATE: _____

Please print neatly and complete all items. Thank you.

PATIENT INFORMATION

Name			Marital Status	
Age	Date of Birth	Gender	Race/Ethnicity (optional)	Preferred pronouns (Optional)
Street Address			City	State
Zip code	Mobile/Main/Preferred Phone	Home/Other Phone	Where may we leave a message? ☐ Mobile/Main Phone ☐ Home/Other ☐ Email ☐ Other_____	
Email (required)				
Employer		Occupation		

REFERRAL

How did you first hear about IPG? (Check one)

☐ Google/Bing, etc ☐ Insurance network ☐ Psychology Today ☐ Good Therapy ☐ Therapy Tribe ☐ Network Therapy ☐ Theravive

☐ Psychiatrist:_____ ☐ Primary Care/Other Doctor: _____

☐ IPG's website ☐ Relative/Friend seen at IPG ☐ Other:_____

What are you looking for help with? (Check up to 3 boxes)

☐ Anger management ☐ Anxiety ☐ Coping with chronic illness ☐ Communication issues ☐ Depression ☐ Grief ☐ PTSD ☐ Panic

☐ Coping with pain ☐ Parenting ☐ Child/School/Behavior problems ☐ Family conflict ☐ Life adjustment/Career issues ☐ Phobias/Fears

☐ Obsessions/Compulsions ☐ Workplace issues ☐ Marital/relationship issues ☐ Other:_____

Will you be requesting a form or letter be completed for you? ☐ Yes ☐ No	What is the form or letter?
Psychiatrist/Prescribing Physician (if applicable)	Phone

EMERGENCY CONTACT (OR IF PATIENT IS A MINOR- **PARENT/GUARDIAN INFORMATION**)

Name	Relationship	Date of Birth (if parent/guardian info)
Home Phone	Cell Phone (Best method of contact))	

INSURANCE (If applicable)

Name of Primary Insured Person		Gender	Patient is the Insured's ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured's Date of Birth	Insurance Company		Member ID#
Name of Secondary Insured Person (if applicable)		*Gender*	*Patient is the Insured's ☐ Self ☐ Spouse ☐ Child ☐ Other*
Secondary insured's Date of Birth	*Insurance Company*		*Member ID#*

Did you receive prior authorization for today's visit? (If applicable) ☐ Yes ☐ No	EAP/Insurance Name	Authorization #