

. Kara Goobic, Psy.D.  
Licensed Psychologist  
8720 Georgia Avenue  
Suite 205  
Phone: (240) 242-9370  
Fax: (301) 495-6394

**Patient Information Form**

Date of Initial Appointment: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Name of Parent: \_\_\_\_\_ (If client is less than 18 years of age)

Permission to Leave message at this Number

Cell Phone: \_\_\_\_\_  Yes  No

Work Phone: \_\_\_\_\_  Yes  No

Home Phone: \_\_\_\_\_  Yes  No

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

I, \_\_\_\_\_, give Kara Goobic, Psy.D.  
permission to communicate with me via email at the following email address) in order to set or  
change appointments, or in response to phone calls or emails from me.

Email Address: \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_  
\_\_\_\_\_, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Who referred you to Dr. Goobic? \_\_\_\_\_

Are you in treatment with a psychiatrist, psychologist, or psychotherapist? Yes No

If so, please provide names and phone numbers: \_\_\_\_\_

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