. Kara Goobic, Psy.D.
Licensed Psychologist
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Patient Information Form

Date of Initial Appointment:_____

Reason for Appointment: _____

Name of Patient:_____

Date of Birth: _____

Preferred Pronouns:

she/her/hers_____

he/him/his _____

they/them/their_____

Permission to Leave message at this Number

Cell Phone: _____ ___Yes _____No

Work Phone:_____ ___Yes _____No

Home Phone:_____ ___Yes _____No

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? Yes _____ No _____

Are you in treatment with a psychologist, or psychotherapist? Yes _____No _____

If so, please provide names and phone numbers:_____
