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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street and #* *City* *State* *Zip*

Phone- home:(\_\_\_\_) \_\_\_\_\_ work:(\_\_\_\_) \_\_\_\_\_ cell:(\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_

OK to leave messages for you at home? \_\_\_\_ work? \_\_\_\_ cell? \_\_\_\_ email? \_\_\_\_ SMS? \_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Emergency contact- Name: \_\_\_\_\_ Phone : (\_\_\_\_) \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Referred by: \_\_\_\_\_

May I thank you referral source for referring you? \_\_\_\_\_

Name of Primary Care Physician (PCP): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

May I inform your Primary Care Physician of your receiving services from me? \_\_\_\_ Yes / \_\_\_\_ No

What is your occupation? \_\_\_\_\_ Employer: \_\_\_\_\_

How did you first hear about my practice? \_\_\_\_\_

Would you be open to taking an anonymous survey about my services in the future? \_\_\_\_\_

Primary Insurance Information

Name of insurance policyholder if not yourself: \_\_\_\_\_ Relation to you: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Insurance Phone #: (\_\_\_\_) \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
*POB or Street* *City* *State* *Zip*

Secondary Insurance Information (if applicable)

Name of insurance policyholder if not yourself: \_\_\_\_\_ Relation to you: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Insurance Phone #: (\_\_\_\_) \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
*POB or Street* *City* *State* *Zip*