Confidential General Information

Date: _____

PATIENT INFORMATION

Full Legal Name: _____
(Last) (First) (MI)

Address: _____

City, State, Zip: _____

Preferred Daytime Phone: ( ) _____ Date of Birth: _____

Social Security: _____ M _____ F _____

Employer: _____ School: _____
(Parent's Employer if client is a minor)

Work Phone: ( ) _____ ext _____ Cell Phone: ( ) _____

Marital Status: Single _____ Married: _____ Other _____

Spouse/Parent Name: _____ Date of Birth: _____

Parent Name: _____ Daytime Phone #: ( ) _____

Parent Name: _____ Daytime Phone#: ( ) _____

Email: _____

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party: _____

Address: _____

City, State, Zip: _____

Daytime Phone: ( ) _____ Cell Phone: ( ) _____

Date of Birth: _____ Social Security: _____

M _____ F _____

Confidential General Information

ADDITIONAL INFORMATION

In Case Of Emergency Contact:

Name: _____ Phone: ( ) _____

Who may we thank for referring you: _____

Previous outpatient phychological/psychiatric counseling with: _____

Date of last visit: _____ Number of mental health visits used this year

Psychiatric Hospitalization: Yes _____ No _____ Dates: _____

Physical Illness/Disabilities:

General Physician:

INSURANCE INFORMATION:

Insurance Company: _____ Policy Number: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscribers Sex: M _____ F _____ Subscriber's Relationship to Patient: _____

Insurance Company: _____ Policy Number: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscribers Sex: M_____ F _____ Subscriber's Relationship to Patient: _____

If subscriber's address is different from patient please fill out below:

Address: _____

City, State, Zip: _____

Daytime Phone: ( ) _____

I authorize the release of any medical information necessary to process claims and request payment of medical benefits to the provider.

Signature of Patient/Legal Guardian: _____ Date: _____