

PATIENT INFORMATION-RESPONSIBLE PARTY

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Patient:

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street and Number) (City) (State) (Zip Code)

Date of birth: _____ SS#: _____ Gender: Male / Female

Home Phone: _____ Work: _____ Cell: _____

May we leave you a message? Yes / No _____

Marital Status: Never Married / Domestic Partnership / Married / Separated / Divorced / Widowed

Student Status: Full Time Student / Part Time Student

E-mail: _____ May we e-mail you? Yes / No

*Please note e-mail correspondence is not considered to be a confidential medium of communication.

Employer: _____

Spouse's Name: _____

Responsible party: If patient is a minor please fill out completely.

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street and Number) (City) (State) (Zip Code)

Date of birth: _____ SS#: _____ Gender: Male / Female

Home Phone: _____ Work: _____ Cell: _____

May we leave you a message? Yes / No _____

Employer: _____

Spouse's Name: _____

Referred by (if any): _____

Insurance Information

Primary Policy Holder Information:

Employer: _____

Date Of Birth: _____ SS# _____

Insurance Company Name: _____

Subscriber ID#: _____

Group#: _____

Secondary Policy Holder Information:

Employer: _____

Date Of Birth: _____ SS# _____

Insurance Company Name: _____

Subscriber ID#: _____

Group#: _____