

Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Ext: _____

Cell Phone: _____ - _____ - _____ Pager: _____ - _____ - _____

E-mail: _____ Fax: _____ - _____ - _____

Gender: Male Female Date of Birth: ____ / ____ / ____

Employment Status: employed student disabled
 employed/student unemployed

Employer: _____

Address: _____

Primary Insurance Company: _____

Secondary Insurance Company: _____

Relationship Status: Married/Committed Single Divorced
 Living Together Separated Widowed

Partner/Spouse: _____

In Case of Emergency, Partner/Spouse's Work Phone: _____ Cell Phone: _____

Other Emergency Contact Person: _____

Relationship to you: _____

Phone: _____ (W) _____ (H) _____ (C)

If patient is minor, parent or guardian _____

Address: _____

Phone: (H) _____ (W) _____ (C) _____



Military Service: Active Reservist None
 Retired Guard Other _____

How Did You Find Us?: _____

Referral Type: self family spouse friend former client
 clergy EAP work court
 school other _____

May we thank this person/agency for the referral? Yes No Maybe

Primary Care Physician: _____ Phone: _____

Address: _____

_____ Fax: _____

May we coordinate services with him/her? Yes No Maybe