

Well Being, LLC

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

**Confidential**

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 \_\_\_\_\_