PATIENT INFORMATION
(Please print and complete)

Patient Name: _____ M.I. ____ Today's Date: _____
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Social Security #:_____ Gender: ☐M ☐F Date of Birth: _____
Gender Identity: _____ Preferred Pronouns: _____
Address: _____City: _____ State: _____Zip Code: _____
Phone Number: (Cell)_____ (Work)_____ (Email)_____
*By providing this information, permission is granted to receive reminder messages via cell phone and email unless otherwise specified.
Name of Spouse (or parents if patient is a child): _____
Responsible Party: _____ Responsible Party's Social Security # _____
Address: _____City: _____State: _____Zip Code: _____
Patient Employed by: _____ Position: _____
In case of emergency, who should we notify? _____
Phone: _____ Relationship: _____
Who referred you to us? _____
Were you referred to a specific therapist? ☐Yes ☐No If yes, who? _____

I authorize the following people to have access to my (or my child's) appointment times and billing/payment information:
Name: _____ Relationship:_____ Exclusions: _____
Name: _____ Relationship: _____ Exclusions: _____

Primary Insurance
Company:_____
Address:_____
Phone:_____
Subscriber Name:_____
Relation to Patient: _____
Date of Birth: _____ Gender: ☐ M ☐F
Social Security#: _____
Policy/ID#: _____
Group#: _____
Address (if different from patient's):
_____
Phone #: _____
Subscriber Employed By:
_____

Secondary Insurance
Company:_____
Address:_____
Phone: _____
Subscriber Name: _____
Relation to Patient: _____
Date of Birth: _____ Gender: ☐ M ☐F
Social Security #: _____
Policy/ID#: _____
Group#: _____
Address (if different from patient's):
_____
Phone #: _____
Subscriber Employed By:
_____

Patient Name: _____ *Responsible Party Signature:* _____