

PATIENT INTAKE FORM – ALL INFORMATION IS CONFIDENTIAL

Name: _____ Date: _____

Address: _____ Apt. #: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Age: _____

Phone (with area code):

Cell: (_____) _____ VM message OK? Yes No Preferred number? Yes No

Home: (_____) _____ VM message OK? Yes No Preferred number? Yes No

Office: (_____) _____ VM message OK? Yes No Preferred number? Yes No

E-mail: _____ OK to reach you by e-mail?* Yes No

*Please note that e-mail correspondence may not be encrypted and may not be confidential. _____ (Please initial)

Insurance Carrier: _____

Person financially responsible for your treatment (if other than you):

Name: _____ Relationship to you: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ E-mail: _____

Emergency Contact:

Name: _____ Relationship to you: _____

Phone: (_____) _____

Primary care physician/provider: _____ Phone: (_____) _____

Referred? _____

Psychiatrist / Therapist: _____ Phone: (_____) _____

Other specialists involved in your care:

Name: _____ Specialty type: _____

Phone: _____ Referred? _____

Name: _____ Specialty type: _____

Phone: _____ Referred? _____

Name: _____ Specialty type: _____

Phone: _____ Referred? _____