Adult Contact Information

Name: _____ Date: _____
Legal Name (if different): _____
Address: _____ Gender: M☐ F☐ Other☐
City: _____ State: _____ Zip: _____ Date of Birth: _____
SS Number: _____

Insurance Information

Primary Health Insurance:_____ Subscriber Name: _____
Relationship to Subscriber:_____ Subscriber Date of Birth:_____
ID number:_____ Group/Policy #: _____

Additional Health Insurance:_____ Subscriber Name: _____
Relationship to Subscriber:_____ Subscriber Date of Birth: _____
ID number:_____ Group/Policy #: _____
Type of Additional Coverage: Secondary ☐ EAP (Employee Assistance Program) ☐

Contact Telephone Numbers

Please complete relevant information and indicate the number at which you wish to be contacted first.

		Phone Messages OK? Yes	Phone Messages OK? No	Primary contact number?
HOME:	( ) _____	☐	☐	☐
WORK:	( ) _____	☐	☐	☐
CELL:	( ) _____	☐	☐	☐

Marital Status

☐ Single ☐ Divorced (____ years) ☐ Living as Married (_____ years)
☐ Married (_____ years) ☐ Separated (_____ years) ☐ Widowed (_____ years)

Spouse's/Partner's Name: _____
If therapist is unable to reach you, is it OK to contact your spouse/partner? Yes☐ No ☐
If yes, spouse/partner's phone number: ( ) _____

Employment Status:

Are you employed? ☐ Yes ☐ No Are you using EAP? ☐ Yes ☐ No

Employer Name: _____

Emergency Contact Information

Name: _____
Address: _____
Phone: ( ) _____ Relationship to you: _____

Primary Care Physician

Current Physician: _____
Physician Address: _____
Physician Phone Number: ( ) _____
Physician Fax Number: ( ) _____

Referent

By whom were you referred?_____