New or Returning Patient Intake

(To be completed again after a 6 month lapse in treatment)

Patient Name	Street Address	City, State & Zip	Day Telephone	Evening Telephone
			( )	( )

Patient Date of Birth	Marital/ Relationship Status	How long in current relationship?	Education Level	

Who may we contact in an emergency?	
Name: **Address:** **Phone:** **Relationship**	**Name:** **Address:** **Phone:** **Relationship:**

Social Security #	Driver's License Number	Employer Name , Address, & Telephone	May we contact you at home? At work?
			Work? **Yes** ☐ **Home?** **Yes** ☐

Your Household Make Up?			
Name:	**Age :**	**Relationship**	**School (if child)**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Insurance Information

Primary Insurance Co:	ID#	Group#
Address:	**City, State, Zip**	
Primary Insured's Name	**Primary Insured's Employer:**	
Primary Insured's Social Security #	**Primary Insured's Date of Birth:**	

Secondary Insurance Co:	ID#	Group#
Address:	**City, State, Zip**	
Secondary Insured's Name	**Secondary Insured's Employer:**	
Secondary Insured's Social Security #	**Secondary Insured's Date of Birth:**	