PATIENT INFORMATION (Confidential) Date _____

Name_____ Sex____ Date of Birth _____

Address_____City_____State_____ZIP_____

Phone (home)_____(work)_____(cell)_____

Employer_____Occupation_____

Circle One: single married divorced widowed separated

Spouse_____Birthdate_____

Spouse Employer_____Work#_____Occupation_____

Referred by_____

POLICY HOLDER or RESPONSIBLE PARTY or PARENT INFORMATION
Complete if patient is a child or dependent OR if someone other than the patient is responsible for payment.

Name_____Relationship to patient_____

Birthdate_____

Address_____City_____State_____Zip_____

Phone(home)_____(work)_____(cell)_____

Employer_____Occupation_____

Circle one: single married divorced widowed separated

Spouse_____ Birthdate _____

SpouseEmployer_____Occupation_____Work#_____

INSURANCE INFORMATION

Insurance Company Name _____ Group #_____
Policy Holder_____ ID# _____
Copay _____ Authorization # _____ Visits Authorized _____
Does Deductible apply? _____ Amount _____ Has it been met?_____
Do you have a health savings account? _____ Is it currently funded? _____

PROVIDER INITIALS: _____ DIAGNOSIS CODE(s) _____

MEDICAL INFORMATION

Primary Care Physician_____

Address_____ Phone_____

Current Medication(s) _____

_____

Medical Problems _____

_____

Substance Abuse issues with self or family _____

Past Sexual Abuse _____

Prior Hospitalization for Behavioral Health _____

Family History of Mental Illness _____

_____

Have you received counseling in the past? _____ If so, please indicate what

was helpful:_____

Was there anything that was not helpful?_____

Reason for seeking counseling/Presenting Issues:_____

_____

PATIENT AGREEMENT STATEMENT:

A) I give my consent to be treated at this facility by my chosen therapist.

B) I have received or been offered a copy of the HIPPA required privacy notice.

C) I am aware that Arizona statute requires the reporting of any evidence of physical or sexual abuse of a minor.

Patient Signature_____Date_____

(GUARDIAN SIGNS IF PATIENT IS A MINOR)