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	E-MAIL

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:	