## *Patient Information* (Confidential)

**Patient's Name**_____

**Address** _____

**City** _____ **State** _____ **Zip** _____

**Home Phone** (____) _____

**Cell Phone** (____) _____

**Work Phone** (____) _____

**Email Address** _____

**Patient's Birthdate** _____

**Patient's SSN** _____

**Patient's Gender** ___ Male ___ Female

**Marital Status:** Married Divorced Single Widow

**Employment Status:** F/T P/T Retired Unempl Student

**Employer** _____

**Occupation** _____

**EMERGENCY Contact** _____

**Phone** _____ **Relationship** _____

**Primary Care Physician** _____

**Referred By** _____

***For marriage counseling, you MUST list your spouse****

**Patient's Name**_____

**Birthdate** _____ **SSN** _____

**IF PATIENT IS A MINOR**

**Mom's Name**_____

**Address** _____

**City** _____ **State** _____ **Zip** _____

**Mom's Phone #** _____

**Dad's Name** _____

**Address** _____

**City** _____ **State** _____ **Zip** _____

**Dad's Phone #** _____

## *Responsible Party*

***DO YOU HAVE MEDICAL INSURANCE?***

___ Yes ___ No – payment is expected in full today

**Insurance Co. Name** _____

**Insurance ID #** _____

**Insurance Group #** _____

**Name of Policyholder** _____

**Address** _____

**City** _____ **State** _____ **Zip** _____

**Home Phone** (____) _____

**Work Phone** (____) _____

**Birthdate** _____ **SSN** _____

**Employer** _____

**Relationship to Patient** _____

***DO YOU HAVE SECONDARY INSURANCE?***

**Insurance Co. Name** _____

**Insurance ID #** _____

**Insurance Group #** _____

**Name of Policyholder** _____

**Address** _____

**City** _____ **State** _____ **Zip** _____

**Home Phone** (____) _____

**Birthdate** _____ **SSN** _____

**Relationship to Patient** _____

## *Signature*

I acknowledge the above information is true. If the patient is under the age of 18; I hereby give my consent, as legal guardian, for Janna Benkelman to treat said minor as a client.

**Signature** _____

**Printed Name** _____

**Date** _____