Smith & Associates Mental Health

Today's Date: __________ **Office Pt ID #** ____________

Demographic Information:
Patient's Name: ____
Date of Birth __________________________________Age:____________________________
SS# ______________________________Ethnicity/Nationality______________________________
Address ________________________________ City ____________________________________
State ______________ Zip __________________ Home Phone ( )________________________
Occupation____________________ Employer____
Email: ____
Marital Status: ( )Single ( )Married ( )Separated ( )Divorced ( )Widowed

If A Minor:
Mother's Name______________________________ Work / Cell Phone_____________________
Father's Name ______________________________ Work /Cell Phone ____________________
Child's grade Level _____________ School ____

In Case of Emergency:
Name____
Phone ____
Relationship to Patient ____

Health Insurance Information:
Insurance Co.____
Name of Insured ____
I.D. # / Policy# ____
EAP Authorization # _____________

Please submit your insurance card with this form:

Revised 09/26/2017