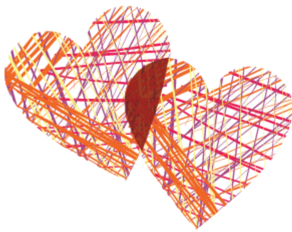

3587 NW Anderson Hill Road
Silverdale, WA 98383
360-434-7097 Direct
360-698-5967 Fax

Information Form

Today's date: ______________________

Personal Information

Name: ______________________ Date of Birth: ______________ Age: _____

Preferred Name or Nicknames: ______________ Social Security #: ______________

Mailing Address: ______________________ Apt: ________

City: ______________________ State: ________ Zip: ________

Home Address (if different): ______________________

Home Phone: ______________________ Mobile Phone: ______________

Can we leave messages?: ______________________

Email: ______________________

Parent/Guardian Information (if applicable)

Parent: ______________________ Date of Birth: ______________ Age: _____

Social Security #: ______________________

Home Address (if different than above): ______________________

Home Phone: ______________________ Mobile Phone: ______________

I allow this person to contacted about my treatment. This may include Information regarding attendance and account billing. Yes:________ No:________

Current Employer (if applicable)

Employer: ______________________ Work phone: ______________

Address: ______________________

City: ______________________ State: ________ Zip: ________

Occupation: ______________________ Length of time with this employer: ________

Please indicate any restrictions on calls: ______________________

Emergency Contact Information

Name: ______________________ Phone: ______________

Address: ______________________

Relationship to you: ______________________

I allow this person to contacted about my treatment. This may include Information regarding attendance and account billing. Yes:________ No:________

How did you hear about us?

Name/Source: ______________________ Relationship: ______________

How did this person recommend I might be of help to you? ______________________

Reason for visit

____ Psychotherapy

____ Wellness Consult

____ Family/Couples Psychotherapy

Please briefly describe:

____

____

____

Medical Care (From whom or where do you or your child get your medical care?; if applicable)

Clinic Name: ______________________________ Phone: ______________________________

Doctor's Name: ____

Address: ____

If you enter treatment with me, may I tell your or your child's medical doctor so that he or she can be fully informed, and we can coordinate your treatment? ❑ Yes ❑ No ❑ N/A

Please list any medical or physical conditions that affect you: ______________________________

Case Manager (If applicable; such as state, parenting coordinator, etc.)

Name: ______________________________ Phone: ______________________________

Fax: ______________________________

Email: ____

Address: ____

May I speak to you case manager so that he or she can be fully informed, and we can coordinate your treatment? ❑ Yes ❑ No ❑ N/A

Insurance (If applicable)

Primary Ins. Co. Name: ______________________ Phone: ______________________

Policy Holder's Name: ______________________ Subscriber #: ______________________

Policy Holder's Address: ______________________ Group #: ______________________

Date of Birth: ______________________ Phone: ______________________

Patient's Relationship to you: ______________________

Secondary Ins. Co. Name: ______________________ Phone: ______________________

Policy Holder's Name: ______________________ Subscriber #: ______________________

Policy Holder's Address: ______________________ Group #: ______________________

Date of Birth: ______________________ Phone: ______________________

Patient's Relationship to you: ______________________

Client or Authorized Person's Signature

I authorized the release of any medical or other information necessary to process claims or complete the evaluation/consultation. **I understand I am responsible for any charges not covered by insurance.** I also request payment of government benefits either to myself or the party who accepts assignment. My signature indicates that I authorize payment of benefits to the provider of services.

Signature: ______________________________ Date: ______________________________

Please provide a copy of your insurance card (if applicable)

Updated: June 2021