Ponderosa Counseling

Adult Registration Form

PATIENT INFORMATION

Patient's Name: Last: _____, First: _____ MI: _____

Date of Birth: _____ Home Phone: _____Cell Phone: _____

Address: _____

City: _____ State: _____, Zip Code: _____

Employer: _____ Work Phone: _____

Preferred Phone: _____

Text OK? Yes _____ No _____

Email Address: _____

Spouse/Significant Other: Last: _____, First _____MI: _____

Date of Birth: _____ Home Phone: _____Cell Phone: _____

Address: _____

City: _____ State: _____, Zip Code: _____

Employer: _____Work Phone: _____

Preferred Phone: _____

Children/ Ages: _____

Emergency Contact: Name: _____ Phone: _____

Relationship: _____

Insurance: _____ ID#: _____Group#: _____

Prescription Plan: _____

Preferred Pharmacy: _____

PRIMARY CARE PHYSICIAN

Doctor's Name: _____Phone: _____

Practice Name: _____

REFERRAL SOURCE

Name: _____ Phone: _____