For office use only:

Date:_____

Day: _____

Time: _____

Avis Augustine-Miller, LPC, LMHC

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Fax: (434) 237-4084
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Patient Information Form

Name _____ Date _____

Address _____City _____ State_____ Zip _____

Phone #s: Home _____ Work _____ Cell _____

Birthdate: _____ SS# _____ Employer _____

Spouse: Name _____ Birthdate _____

Employer _____ Phone# _____

Family Members	Ages	Relation	Comments

Previous Professional help? _____ Yes _____ No

If yes, by whom? _____ Date last seen: _____

Current medications: _____ PCP: _____

Insurance Company: _____ ID#: _____

Referred by: _____

Reason for referral: _____