

Please provide the following information and answer the questions below. Please note that the information you provide here is protected as confidential information.

**NAME:** \_\_\_\_\_  
Last First Middle Initial

**ADDRESS:** \_\_\_\_\_  
Street and Number City State Zip Code

*(if minor, please complete)*

**NAME OF PARENT(S)/GUARDIAN(S):** \_\_\_\_\_  
Last First

**CONTACT INFORMATION:**

HOME PHONE: \_\_\_\_\_ *May I leave a message?* yes no

CELL PHONE: \_\_\_\_\_ *May I leave a message?* yes no

WORK PHONE: \_\_\_\_\_ *May I leave a message?* yes no

**E-MAIL ADDRESS:** \_\_\_\_\_

*Please note that email correspondence is not considered to be a confidential means of communication.*

**DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **GENDER:** Female Male

**MARITAL STATUS:**

Never Married Married Domestic Partner Separated Divorced Widowed

**PLEASE LIST ANY CHILDREN AND THEIR AGE (S):**

\_\_\_\_\_

**OTHER HEALTH/SERVICE PROVIDERS** *(e.g. Primary Care Physician, Psychiatrist, etc.):*

NAME: \_\_\_\_\_ PROVIDER ROLE: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ PROVIDER ROLE: \_\_\_\_\_

PHONE: \_\_\_\_\_

**EMERGENCY CONTACT (S):**

NAME: \_\_\_\_\_ RELATIONSHIP to PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_