Preferred Care Counseling, LLC

www.preferredcarecounseling.com

PATIENT INFORMATION:

Last Name: _____First Name :_____Initial:_____

Date of Birth:_____ Age:_____ Gender: □ Male □ Female

Social Security Number: _____ - _____ - _____

Address: _____

City:_____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____ Email:_____

Marital status: □ Single □ Married □ Separated □ Divorced □ Widowed

Name of Spouse/Partner (if applicable): _____

Employment Status: □ Full-time □ Part-time □ Retired □ Unemployed □ Disabled

Place of Employment: _____Work Phone: _____

Student Status (for child or adult): □ Full-time □ Part-time Attending: _____

FOR MINORS (Under age of 18 ONLY):

Mother's Name: _____

Address (if different): _____ Phone: _____

Father's Name: _____

Address (if different): _____ Phone: _____

EMERGENCY CONTACT:

Name of Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____Work Phone: _____

PRIMARY CARE PHYSICIAN:

Primary Care Physician: _____ Phone: _____

Address: _____