Office Use Only:
Therapist _______________ Dx ________

Patient Information (Please **print** and **complete** form in its entirety)

Name (First, MI, Last) ____ SSN ______________________________
Date of Birth (MM/DD/YY) _____/_____/______ Age: ________ Gender (circle one): **M** or **F**
Street Address (required): ______________________________ City ______________ State _____ Zip _________
Phone Numbers: Cell ( ) _______________ Work ( ) ________________ Other ( ) ______________________
Is it okay to leave medical or confidential information in a **voice mail** at the above numbers? **Y** or **N**
Email Address: ____
Employer or School Name _____________________________________ May we contact you at work? **Y** or **N**
Employer Address ___________________________________ City _______________ State ______ Zip ________
Emergency Contact (Name/Phone/Relationship) ____

Responsible Party (If Patient is a minor – under 18 years of age)
The information below must be the parent/guardian who is present at the appointment.
Name (First, MI, Last) ____ SSN ______________________________
Date of Birth (MM/DD/YY) _____/_____/______ Age: ________ Gender (circle one): **M** or **F**
Street Address (required): ______________________________ City ______________ State _____ Zip _________
Phone Numbers: Cell ( ) _______________ Work ( ) ________________ Other ( ) ______________________
Is it okay to leave medical or confidential information in a **voice mail** at the above numbers? **Y** or **N**
Employer or School Name _____________________________________ May we contact you at work? **Y** or **N**
Other Parent/Guardian: Name ________________________________ Primary Phone: ( ) _________________

Insurance Information (Complete this even though we will copy your insurance card)
Insurance Company ____ Phone Number ( ) __________________
Member ID # ____ Group # ____________________________
Subscriber Name ________________________________ Subscriber Date of Birth (MM/DD/YY) ____/____/____
Subscriber SSN __________________________________ Subscriber Primary Phone ( ) ____________________
Subscriber Street Address (required – if different) ___________________ City _________ State ___ Zip _______
Subscriber Employer ____
Employer Address ___________________________________ City ______________ State _____ Zip __________
Relationship to Patient (circle one): Self / Spouse / Child / Other - _____________________________________

Secondary Insurance Information (Complete this even though we will copy your insurance card (s))
Insurance Company ____ Phone Number ( ) __________________
Member ID # ____ Group # ____________________________
Subscriber Name ________________________________ Subscriber Date of Birth (MM/DD/YY) ____/____/____
Subscriber SSN __________________________________ Subscriber Primary Phone ( ) ____________________
Subscriber Street Address (required – if different) ___________________ City _________ State ___ Zip _______
Relationship to Patient (circle one): Self / Spouse / Child / Other - _____________________________________

I have reviewed the above information and it is true and correct to the best of my knowledge.

_________________________________ _________________________________ __________________
Signature of Responsible Party Print Name Date

Chesterfield Office
6603 Irongate Square
N. Chesterfield, VA 23234
804-743-0960 OFFICE
804-743-1175 FAX

Powhatan Office
2164 Plainview Center
Powhatan, VA 23139
804-598-5300 OFFICE
804-598-5511 FAX

Midlothian Office
831 Grove Road, Suite C
Midlothian, VA 23114
804-794-6600 OFFICE
804-794-6606 FAX

FamilyGuidanceCenters.com