PATIENT DEMOGRAPHIC FORM

Patient Name:				**Date of Birth:**			
Social Security #:				**Gender:**		Male	Female
Address:		**City:**		**State:**		**Zip:**	
(H) Tel.		**(W) Tel.**		**Cell**			
Employer:		**Occupation:**					

IF PATIENT IS A MINOR							
MOTHER'S NAME:				**Date of Birth:**			
Address:		**City:**		**State:**		**Zip:**	
(H) Tel.		**(W) Tel.**		**Cel.**			
Employer:		**Occupation:**					
FATHER'S NAME:				**Date of Birth:**			
Address:		**City:**		**State:**		**Zip:**	
(H) Tel.		**(W) Tel.**		**Cel.**			
Employer:		**Occupation:**					

EMERGENCY INFORMATION			
Emergency Contact:		**Relationship:**	
(H) Tel.:		**Cell:**	

REFERRAL INFORMATION	
Referral Source:	
Tel. :	
Service Requested:	

CHIEF COMPLAINT

INSURANCE INFORMATION					
Primary Insurance:			**Member Identification #:**		
Marital Status:	Sin Mar Div Sep Wid		**Group #:**		
Subscriber First Name:		**Last Name:**		**Date of Birth:**	
Subscriber Employer:			**Subscriber Soc. Sec. #:**		
Relationship to Insured:					
Insurance Tel. *(Mental Health, Behavioral Health, or Providers):*					
Secondary Insurance:			**Member Identification #:**		
Marital Status:	Sin Mar Div Sep Wid		**Group #:**		
Subscriber First Name:		**Last Name:**		**Date of Birth:**	
Subscriber Employer:			**Subscriber Soc. Sec. #:**		
Relationship to Insured:					
Insurance Tel. *(Mental Health, Behavioral Health, or Providers):*					

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [A.M.A. Counseling Services, LLC] or insurance company to release any information required to process my claims.

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Patient/Guardian signature *Date*