PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION:

Today's Date:____________________________

Patient's Name:____ Patient's Soc. Sec. #:______________________

Date Of Birth:____________________________ Sex: M ☐ F ☐ Marital Status: S ☐ M ☐ D ☐ W ☐

Street Address:____

City:____ State:__________________ ZIP:______________________

Home Phone: (_____) __________________________ Work Phone: (_____) ____________________________________

Cell: (_____) _________________________________ Email Address:____

Emergency Contact:____________________________ Emergency Contact Phone: (_____) _________________________

Occupation: __________________________________ Employer: ____

How did you hear about Philmont Guidance Center:____

INSURANCE SUBSCRIBER'S INFORMATION:

Subscriber/Parent Name:____ Relationship to Patient:____________________

Subscriber's Social Security Number: ____________________________ Date of Birth:______________________________

Subscriber's Address:____

City:____ State:__________________ ZIP:______________________

Home Phone: (_____) __________________________ Work Phone: (_____) ____________________________________

Cell: (_____) _________________________________ Email Address:____

For minor child, please list other parent's information:

Name:_______________________________________ Cell: ______________________ Work:___________________

Address:____

PATIENT INSURANCE INFORMATION *****please provide insurance card to therapist/receptionist*****

Primary Insurance Company's Name:_______________________________ Name of Subscriber:_______________________

Relationship to Patient:____ Date of Birth:______________________________

Insurance ID Number:____ Group:__________________________________

Secondary Insurance Company's Name:____

Name of Policy Holder:____________________________ Date of Birth:____

Insurance ID Number:______________________________ Group Number:____

I HAVE AN ADVANCED DIRECTIVE/INSTRUCTION FOR MENTAL HEALTH TREATMENT ☐ YES ☐ NO

(If yes, you must provide Philmont Guidance with a copy of the advance directive)

FOR OFFICE USE ONLY

Clinician Signature: _________________________________ Name/Degree: ______________________________________

Patient Diagnosis Code(s): ____

Revised 02/2012