COLUMBIA COUNSELING CENTER, P.A.
(Please Print)

This box for Administrative Use Only

Account #: _____ Date:_____ Scanned_____ Attached_____ Entered_____
Provider: _____
Primary Insurance: _____Secondary Insurance: _____ MD Referral Needed: ☐ OTR Needed: ☐

Patient Information Today's Date _____

Patient Name: _____ _____ _____ **Sex:** ☐ **Male**
Last First Middle Initial ☐ **Female**

Date of Birth: ____ ____ _____ Age: _____ **Social Security #:** _____ - ____ - _____
Month Day Year

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow

Home Address: _____ Apt #_____ **Home Phone:** (____) _____ - _____
_____ **Cell Phone:** (____) _____ - _____
City State Zip Code **Work Phone:** (____) _____ - _____
Email Address: _____ **Correspondence sent via Email:** ☐ opt in ☐ opt out

Occupation: ☐ Full Time ☐ Part Time ☐ Unemployed☐ Full Time Student ☐ Part Time Student (check all that apply)

Name of Employer/School: _____
Address: _____
_____
City State Zip Code

Previous Mental Health Treatment (within 2 years) ☐ Psychiatrist ☐ Psychologist ☐ LCSW ☐Other

Mental Health Provider: Name _____ Phone: (____) _____ - _____
Address _____
_____

Current Primary Physician: Name _____ Phone: (____) _____ - _____
Address _____
_____

Family Information:

Person Responsible for Account: ☐ Patient ☐ Spouse ☐ Parent ☐ Other

Name: (If different from Patient) _____ _____ _____
Last First Middle Initial

Date of Birth: ____ ____ _____ Age: _____ **Social Security #:** _____ - ____ - _____
Month Day Year

Address: (If different from Patient) _____ Apt #_____
_____
City State Zip Code

Employer of Responsible person: _____ **Work Phone:** (____) _____ - _____
_____
City State Zip Code

Referral Information:

Referred by: ☐ Physician ☐ Insurance Co. ☐ Relative ☐ Friend ☐ CCC Website ☐ Other Website_____
Name & Address: _____
Phone Directory: ☐ Columbia Directory ☐ Yellow Pages ☐ The One Book ☐ Other: _____