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PATIENT INFORMATION SHEET

PATIENT'S NAME: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____
STREET CITY STATE ZIP CODE

DATE OF BIRTH: _____/_____/_____ SEX: ☐ MALE ☐ FEMALE MARITAL STATUS: S M D W

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

CELL PHONE: ( ) _____ E-MAIL: _____

SOCIAL SECURITY NUMBER: _____-_____-_____ **I prefer to be called** _____

EMPLOYER: _____ POSITION: _____

ADDRESS: _____
STREET CITY STATE ZIP CODE

RESPONSIBLE PARTY IF OTHER THAN ABOVE: _____ PHONE: ( ) _____

ADDRESS: _____ RELATIONSHIP TO PATIENT: _____

IN CASE OF EMERGENCY:

CONTACT: _____ CONTACT: _____

ADDRESS: _____ ADDRESS: _____

PHONE: ( ) _____ PHONE: ( ) _____

I authorize Dottie J. Miller, LCSW, LMFT, LPC, to release any and all information to my insurance companies. I assign all medical benefits to Dottie J. Miller, LCSW, LMFT, LPC, for any and all services provided by her. I authorize Dottie J. Miller, LCSW, LMFT, LPC , to request from any source information required to assist in my medical care. I agree to pay Dottie J. Miller, LCSW, LMFT, LPC for any and all services provided to me or on my behalf by her, regardless of my insurance coverage. I authorize Dottie J. Miller, LCSW, LMFT, LPC to contact me in the future for the purpose of gathering data for research. All such data will not identify you as providing it.

_____ _____
Patient Signature Date