JANE C PATTERSON, MSW, LCSW

PATIENT INFORMATION: *Welcome to our office. In order to use your current health insurance more effectively, please complete the following information*

DATE OF APPOINTMENT: _____

Last name: _____ **First name:** _____ **M.I.:** _____

Address: _____ **City, state:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Work #** _____

Employer: _____ **Position:** _____

Employment Status:

Full-time: ☐
Part-time: ☐
Unemployed: ☐
Retired: ☐

Student Status:

Full-time: ☐
Part-time: ☐
Not a student: ☐

Marital Status:

Single: ☐
Married: ☐
Separated: ☐
Divorced: ☐
Living with significant other: ☐

Sex:

Male: ☐
Female: ☐

Date of Birth: _____

Email address: _____

Referred by: _____ **Primary care physician:** _____

Please list all the medications now taking and their dosage: _____

_____

PARTNER INFORMATION:

Last name: _____ **First name:** _____ **M.I.:** _____

Address: _____ **City, state:** _____ **Zip:** _____

Home phone: _____ **Cell phone:** _____ **Work:** _____

Employer: _____ **Position:** _____

Employment Status:

Full-time: ☐
Part-time: ☐
Unemployed: ☐
Retired: ☐

Student Status:

Full-time: ☐
Part-time: ☐
Not a student: ☐

Marital Status:

Single: ☐
Married: ☐
Separated: ☐
Divorced: ☐
Living with significant other: ☐

Sex:

Male: ☐
Female: ☐

Date of Birth: _____

Please list all the medications and dosage: _____

_____

INFORMATION CONCERNING POLICYHOLDER: PRIMARY INSURANCE

Name of Policyholder: _____ Date of Birth: _____

Address (if different from above): _____

Home/cell phone:_____ work phone: _____ Ext.: _____

Relationship to patient: **Insurance company:** _____

Self: ☐ policyholder Social Security #: _____

Spouse: ☐ name of employer: _____

Parent: ☐ group number: _____

Group name: _____

INFORMATION CONCERNING POLICYHOLDER: SECONDARY INSURANCE

Name of Policyholder: _____ Date of Birth: _____

Address (if different from above): _____

Home/cell phone:_____ work phone: _____ Ext.: _____

Relationship to patient: **Insurance company:** _____

Self: ☐ policyholder Social Security #: _____

Spouse: ☐ name of employer: _____

Parent: ☐ group number: _____

Group name: _____