

EDGEWATER COUNSELING CENTER

If patient is *YOUR CHILD*, please print *YOUR CHILD'S* information in *PATIENT SECTION*
PARENT information (*YOUR INFORMATION*) goes in the *INSURED SECTION*

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ SEX: M F
STREET _____ MARITAL STATUS: Sing Mar Sep Div
CITY, STATE, ZIP _____ BIRTH DATE _____ AGE _____
HOME PHONE () _____ SS# _____
WORK PHONE () _____ EMPLOYER NAME _____
EMERGENCY CONTACT (name, phone) _____
REFERRED BY (name, phone) _____

INSURED INFORMATION PLEASE COPY INFORMATION FROM INSURANCE CARD

INSURANCE COMPANY _____ ID# _____
INSURANCE ADDRESS _____ PHONE () _____

PATIENT RELATION TO INSURED: SELF SPOUSE CHILD
IF OTHER THAN SELF, PRINT *INSURED* INFORMATION BELOW

NAME _____ BIRTH DATE _____ SS# _____
STREET _____ CITY, ZIP _____
NAME OF EMPLOYER _____

The following paragraphs (reverse side) list the most important office policies. PLEASE READ CAREFULLY. Your signature on the next page will indicate that any questions you had regarding the following information were answered to your satisfaction and that you are in agreement with those office policies that are applicable to you. You are encouraged to discuss any questions about policy. You are assured of receiving the best available treatment regardless of age, race, religion, sexual orientation or insurance type. WELCOME