Patient Information Sheet

LIVING WELL BEHAVIORAL HEALTH, INC.

PATIENT Full Name: _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ E-mail address: _____

Ph #: Hm: _____ Wk: _____ Cell: _____ Sex: M ☐ F ☐

Date of Birth: _____ Marital Status: _____ Soc. Sec. #: _____

Employer: _____ ☐ Full-Time ☐ Part-Time

RESPONSIBLE PARTY (Name On Insurance) Name:_____

Relationship to Patient: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

Ph.#: Hm: _____ Wk: _____ Cell: _____ Sex: M ☐ F ☐

Date of Birth: _____ Marital Status: _____ Soc. Sec. #: _____

Employer: _____ ☐ Full-Time ☐ Part-Time

PRIMARY CARE PHYSICIAN: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone Number: (_____)_____

EMERGENCY CONTACT Name:_____
(Parent or Guardian for Minors)

Phone No.: Home: _____Work: _____ Cell: _____

REFERRED BY: _____Clinic: _____

☐ Google ☐ Patient ☐ Other _____