ALONG THE PATH COUNSELING SERVICES, P.C.

PATIENT INFORMATION **Today's Date:** _____

NOTE: The information you provide is confidential. Provide as much information as feels comfortable to you.

Name: _____ _____ _____
First Middle Last

Nickname: _____ **Date of Birth:** _____ **SSN:** _____

Gender: ☐ **Male** ☐ **Female**

Relationship Status: ☐ **Single** ☐ **Unmarried Couple** ☐ **Married**
☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Employment: ☐ **Employed - if checked, specify where:** _____

☐ **Full-Time Student** ☐ **Part-Time Student** **Unemployed/Other:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Mobile Phone: _____ **Home Phone:** _____

Work Phone: _____ **Other Phone:** _____

E-Mail Address: _____

Do you want appointment reminders? ☐ **No Reminder** ☐ **Text** ☐ **E-mail** ☐ **Phone**

Is it OK to leave a voice message or text message on your mobile or home phone? ☐ **Yes** ☐ **No**

Please specify ☐ **Voice only** ☐ **Text only** ☐ **Both**

My preferred phone is ☐ **Cell** ☐ **Home** ☐ **Other**_____

My primary language is ☐ **English** ☐ **Spanish** ☐ **ASL** ☐ **Other** _____

Do you have health insurance? ☐ **Yes** ☐ **No**

If yes, complete an Insurance Coverage Form.

Is someone other than yourself responsible for payments on your account? ☐ **Yes** ☐ **No**

If yes and if you are 18 years of age or older, a release of information must be completed for this person as well as a financial addendum agreement.

Please sign and date on the back

PATIENT INFORMATION Continued

Emergency Contact Name: _____

Relationship: ☐ **Mother** ☐ **Father** ☐ **Guardian** ☐ **Spouse/Partner** ☐ **Friend**
☐ **Other:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Mobile Phone: _____ **Home Phone:** _____

Work Phone: _____ **Other Phone/Fax:** _____

E-Mail Address: _____

Appointment reminders for this person? ☐ **No Reminder** ☐ **Text** ☐ **E-mail** ☐ **Phone**

Would you like anyone else to be your Emergency Contact? ☐ **Yes** ☐ **No**

If yes, Name: _____

Relationship: ☐ **Mother** ☐ **Father** ☐ **Guardian** ☐ **Spouse/Partner** ☐ **Friend**
☐ **Other:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Mobile Phone: _____ **Home Phone:** _____

Work Phone: _____ **Other Phone/Fax:** _____

E-Mail Address: _____

Appointment reminders for this person? ☐ **No Reminder** ☐ **Text** ☐ **E-mail** ☐ **Phone**

By signing this form, I agree that all information is true and accurate, to the best of my knowledge. I furthermore authorize Along The Path Counseling Services P.C. to communicate with my emergency contact(s) should a need present itself. My provider, per their judgment and discretion, will determine such a need. If medical records are to be disclosed to my emergency contact person, an additional signed Release of Information is required.

Signature(s): _____ **Date:** _____
(if patient is a minor, parent or legal guardian sign)