

# WELCOME!

## PERSONAL INFORMATION

We warmly welcome you to our community.

Information is requested after the specific agencies are chosen so that we can better serve you. Please be sure to fill out all sections of this form. Information is needed for a variety of reasons, including your admission to the program. Please provide all information requested. The information that is being requested is as follows:

### Personal Information

Mr./Ms./Mrs./Miss (please print)

Age (or nearest age) (please print)

Place of birth (state, country) \_\_\_\_\_ Day of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Social Security Number \_\_\_\_\_

Spouse/partner/other partner \_\_\_\_\_ (please print name) \_\_\_\_\_

### Employment

Full-time/Part-time/Retired/Student

Place of employment (if any) \_\_\_\_\_ Address \_\_\_\_\_

### Medical Information

Insured by \_\_\_\_\_

Insured by \_\_\_\_\_

Insured by \_\_\_\_\_

Insurance (if any) (please print) \_\_\_\_\_

Primary Doctor's Name \_\_\_\_\_

Referring to Patient \_\_\_\_\_

Primary Doctor's Office (if any) \_\_\_\_\_

Social Security Number (if any) \_\_\_\_\_

Primary Doctor's Employer \_\_\_\_\_

Referral: (what was the reason for referring you to our office?) \_\_\_\_\_

Consent: I hereby consent to the collection, use, and disclosure of my personal and confidential information for the purposes of providing me with comprehensive health care services, including diagnosis, treatment, and research. I understand that my information may be used for purposes other than those stated above. I understand that my information may be used for purposes other than those stated above. I understand that my information may be used for purposes other than those stated above.

Consent: I hereby consent \_\_\_\_\_