Cedar Tree Counseling

PERSONAL HISTORY (ADULT)

PATIENT

Patient's Last Name:	First Name (legal):	Middle Name:	Nickname:
Address:	City:	State:	Zip Code:
Age: / Date of Birth: / Sex: ☐ M ☐ F / SS# (required):		Home Phone:	
Home Email:		Cell Phone:	
☐ **SELF**			
Employer:	Occupation:	Work Phone:	
Employer Address:	City:	State:	Zip Code:
Work Email:			

SPOUSE

☐ **SPOUSE**				
Name (last):	First:	M.I.	DOB:	Social Security No:
Address:	City:	State:	Zip Code:	
Home Email:	Home Phone:	Cell Phone:		
Employer:	Occupation:	Work Phone:		
Employer Address:	City:	State:	Zip Code:	
Work Email:				

IN CASE OF EMERGENCY

Name of Relative or Authorized Person to Notify in Case of Emergency:	Relationship:
Home Phone:	Work Phone:
Street Address: / City: / State: / Zip Code:	

Primary Care Physician: _____

Who referred you to our practice: _____

Please provide a current insurance card for the receptionist.
All copays are due at time of service.

I also realize that if I am turned over to a collection agency to obtain payment for services rendered, I will be responsible for legal collection fees. We will not be involved in legal disputes.

_____ _____ _____

Signature Relationship Date