BRENTWOOD COUNSELING ASSOCIATES

Name: ____________________ **Date Of Birth:** ____________ **Age:** __________

Address: ______________________ **City:** ____________ **State:** ___ **Zip:** ______

Home Phone: ____________ **Okay to contact you at home?** yes _____ no _____

Cell Phone: ____________ **Okay to contact on your cell?** yes _____ no _____

Employer: ______________________________ **SS #** ________________

Work Phone: ____________ **Okay to contact you at work?** yes _____ no _____

Marital Status: Married ____ Single ____ Separated ____

Divorced ____ Widowed ____ Partnered ____

Spouse/Partner: __________________ **Date of Birth:** __________ **Age:** ________

Home Address (if different): ______________________________

Employer: ____

Work Phone: ______________ **Okay to contact at work?** yes _____ no _____

Cell Phone: ______________ **Okay to contact on cell?** yes _____ no _____

Children: (name/age) ______________________________________

____

Previous Counseling Within Past Year? yes _______ no _______
If yes, did you file with insurance? yes _______ no _______

Insurance Company: ____________________________________

Policyholder's Name: ______________________ **Date of Birth:** __________

Policyholder's SS #: ______________ **Relation to patient:** ______________

Primary Care Physician ____________________________________

How did you hear of us? ____________________________________

Presenting Problem: ____

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If insurance is being used, I authorize release of information needed to process insurance claims and that benefits be paid directly to provider. I understand I am responsible for all charges incurred not paid by insurance and that payment is expected at the time of service.

______________________________ ______________________

Signature ***Date***