

Cedar Ridge Counseling Centers Patient Information

Referred By: \_\_\_\_\_

**Therapist:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Home # \_\_\_\_\_ Work \_\_\_\_\_ Cell: \_\_\_\_\_

Employer: \_\_\_\_\_ Soc Sec # \_\_\_\_\_

Marital Status: \_\_\_\_\_ How Long: \_\_\_\_\_ M \_\_\_ F \_\_\_\_\_

Complete if Patient is under age 18:

School: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work# \_\_\_\_\_

Employer: \_\_\_\_\_ How Long: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work # \_\_\_\_\_

Employer: \_\_\_\_\_ How Long: \_\_\_\_\_

**Patient's Primary Ins. Co:** \_\_\_\_\_ Phone # \_\_\_\_\_

Patient's Membership #: \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder Information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ SS# \_\_\_\_\_

Deductible: \_\_\_\_\_ Copay (Estimated) \_\_\_\_\_

**Patient's Secondary Ins. Co** \_\_\_\_\_

Phone # \_\_\_\_\_

Membership # \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Co-pay \_\_\_\_\_

If we are unable to contact you, please list the closest relative or friend:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

I authorize the release of any medical information necessary to process this claim, payment of medical benefits to the physician or supplier of services and the release of medical information to my primary care physician.

**Signed** \_\_\_\_\_ **Date:** \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone# \_\_\_\_\_

Diagnosis: \_\_\_\_\_

