# DK Counseling Services
# Patient Information Form

dkcounselingservices@gmail.com

**Today's Date**

**Patient Name** **First** **MI** **Last**

**Gender** **Date of Birth** **Age** **Marital Status**

**Full-Time Student** ◯ **Yes** ◯ **No** **Primary Ph #:**

**Permission to Leave Message?** ◯ **Yes** **Other Ph #:**

**Address** **City**

**State** **Zip** **Email**

**Who has primary (financial) responsibility for this patient**

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**If someone other than patient has primary responsibility, please complete following:**

**Name** **Date of Birth**

**Contact Information: Same as Above?** ◯ **Yes** ◯ **No, please provide below:**

**Home #** **Cell#** **Work#**

**Preferred Phone #**

**Address** **City**

**State** **Zip** **Email**

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**Insurance Information ▶** ◯ **None, skip to bottom (**primary care physician.**)**

**Insurance Carrier:** ◯ **Aetna** ◯ **Blue Cross/Blue Shield** ◯ **Cigna** ◯ **Humana**

◯ **Other (Out of Network), Specify**

**Name of Policy Holder** **DOB**

**Patient's Relationship to Insured** **Insured's ID#**

**Insurance Co. Phone # for Mental Health Benefits (from back of ID card)**

***▲This information is vital to confirming your insurance benefits prior to your first appointment and avoiding unnecessary charges!***

**Name of referring or primary care physician.**

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**Emergency Contact Name & Number:**

**Name:** _____ **Phone:** _____

**Please list the names of other family members and their relationship to patient.**

| Name of Family Member: | Date of Birth | Lives in same Hshld as patient | | Relationship |
|---|---|---|---|---|
| | | ☐ Yes | ☐ No | |
| | | ☐ Yes | ☐ No | |
| | | ☐ Yes | ☐ No | |
| | | ☐ Yes | ☐ No | |
| | | ☐ Yes | ☐ No | |

**Describe the symptoms or circumstances that prompted you to seek counseling.**

**List medications the patient is currently taking or has taken in the past two years.**

| Name of Medication | Taking Currently | Taken in Past | Why Stopped |
|---|---|---|---|
| | ☐ | ☐ | |
| | ☐ | ☐ | |
| | ☐ | ☐ | |
| | ☐ | ☐ | |
| | ☐ | ☐ | |

**THANK YOU!**

**Please click the Accept button once you have reviewed your entries** By clicking Accept, you (responsible party named above) agree to take financial responsibility for all fees for services not covered by insurance.

Please print form and bring to first visit or scan and email to dkcounselingservices@gmail.com. Thank you.