Laura M. Lentz, LIMHP 17940 Welch Plaza #106 Omaha, NE 68135 402-881-0872

NEW PATIENT INFORMATION PACKET

I thank you in advance for taking the time to fill out the following as completely as possible.

First Name: _____ M.I. ___ Last Name: ____

PATIENT'S INFORMATION

у	State:	Zip Code:	Marital Status: M S O
mary Phone: condary Phone:			her OK to text as reminders?
nail address:		Names and DOB	of children:
cial Security:		Birthdate:	Sex (M/F)
nployed (Y/N) E me of Spouse:	Employer / School:	DOB of spouse:	Employer:
ergency Contact Name/A	Address/Number		
eet Address:			
	State:	•	
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•	Have you ever been hospitalized for mental health or chemical dependency treatment?			
•	Have you ever attempted suicide? If yes, when			
	How often do you drink alcohol? How many drinks/avg per occasion?			
•	Education: Degree completed			
•	Legal issues? If yes, please describe			
•	Military Service? If yes, please describe rank and time frame			
•	Any health issues that you would like to describe:			
•				
•	Please describe if you currently engage in exercise, and if so how often			
	Current Medications and dosages:			
	Any other information that you would like to provide:			
	CONSENT TO TREATMENT			
I,	, consent for treatment for therapy/counseling for your name			
() mvs	self or for () minor			
() iiiy3	self or for () minor Minor's name			
	a M. Lentz, LIMHP (therapist). I grant Laura Lentz to perform the procedures and treatment necessary for my condition that erally used in this and similar settings.			
	PRIVACY PRACTICES			
	equest a current copy of Laura M. Lentz, P.C. privacy practices for Protected Health Information at any time. I understand that I Lentz, P.C. has the right to change the Notice of Privacy Practices at any time.			
By signi stated a	ng below certifies that he or she has read the foregoing, is the patient or the legal guardian and is accepting the terms as above.			
	Signature date			