



**Cedar Ridge Counseling Centers Patient Information**

**PLEASE PRINT**

**Adult**    **Child**

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

Patient's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

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

City, ST, Zip \_\_\_\_\_

PH: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

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

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

Complete if patient is a child:

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: \_\_\_\_\_ D.O.B. \_\_\_\_\_

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

Relationship to Patient: \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Co-Pay \$ \_\_\_\_\_ Authorization # \_\_\_\_\_

**CEDAR RIDGE COUNSELING CENTERS, LLC DOES NOT BILL FOR SECONDARY INSURANCE.**

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

**Client Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If Minor, Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

DIAGNOSIS: \_\_\_\_\_ Referred by \_\_\_\_\_