Cedar Ridge Counseling Centers Patient Information

☐ **New Patient** ☐ **Updated Information** ☐ **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 ONLY 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 for primary insurance:

Name: _____ DOB_____ Soc. Sec #_____

Insured's Employer: _____Relationship: _____

Secondary Ins. (if applicable) _____Phone #_____

Patient's Membership #: _____ Group #: _____

Policy Holder Information for secondary insurance:

Name: _____ DOB_____ Soc. Sec #_____

Insured's Employer: _____Relationship: _____

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

☐ ***YES, I give CRCC permission to use my CELL number listed above to send appointment reminders**
****Please use email address above for appointment reminders**

Client Signature_____**Date**: _____

If Minor, Guardian Signature_____ **Date:** _____

Primary Care Physician: _____ Phone # _____