LAST NAME:		**FIRST NAME:**	**M.I.**
D.O.B:	**GENDER:** ❑ Male ❑ Female ❑ Transgender	**MARITAL STATUS:** ❑ Single ❑ Married ❑ Divorced ❑ Widowed	
SOCIALSECURITY NO.		**PREFERRED LANGUAGE**: ❑ English ❑ Other ❑ Indian ❑ Spanish ❑ Russian	
RACE: ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian/Other Pacific ❑ Black or African American ❑ White ❑ Hispanic ❑ Other Race		**ETHNICITY:** ❑ Hispanic or Latin ❑ Not Hispanic or Latin ❑ Refuse to Report	
HOME ADDRESS:		**CITY**	**STATE** / **ZIP**
HOME PHONE:	**CELL:**	**EMAIL:**	
EMPLOYER:		**WORK PHONE:**	
ALLERGIES (Medical Alert):			
Pharmacy:			
PRIMARY CARE PHYSICIAN:	**PHONE:**	**REFERRING PHYSICIAN:**	
Pending Legal Issues (arrest, probation)			
Small Detail of what brings you to the Office:			
IN CASE OF EMERGENCY CONTACT			
FIRST NAME:	**LAST NAME:**	**RELATION:**	**PHONE:**
INSURANCE INFORMATION: PRIMARY			
Insured Name:	**Relationship to Patient:**	**DOB:**	
Insurance Company:			
Insurance Company Address:			
City:	**State:** / **ZIP:**	**Phone:**	
Policy No:	**Group No:**	**Employer:**	
INSURANCE INFORMATION: SECONDARY			
Insured Name:	**Relationship to Patient:**	**DOB:**	
Insurance Company:			
Insurance Company Address:			
City:	**State:** / **ZIP:**	**Phone:**	
Policy No:	**Group No:**	**Employer:**	

STATEMENT OF FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFIT: I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of the Progressive Care Counseling. I assign and authorize payments to Progressive Care Counseling. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or state or federal law. **I give permission to leave phone message(s): ☒ YES ☒ NO**

Patient Signature and/or Guardian Date

PROGRESSIVE COUNSELING CENTER - CLIENT DEMOGRAPHIC FORM