

LAST NAME:		FIRST NAME:		M.I.
D.O.B:	GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender		MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
SOCIAL SECURITY NO.		PREFERRED LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Other <input type="checkbox"/> Indian <input type="checkbox"/> Spanish <input type="checkbox"/> Russian		
RACE: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other Race		ETHNICITY: <input type="checkbox"/> Hispanic or Latin <input type="checkbox"/> Not Hispanic or Latin <input type="checkbox"/> 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:
<p>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): <input type="checkbox"/> YES <input type="checkbox"/> NO</p>				
<hr/> Patient Signature and/or Guardian				<hr/> Date