

<b>LAST NAME:</b>		<b>FIRST NAME:</b>		<b>M.I.</b>
<b>D.O.B:</b>	<b>GENDER:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender		<b>MARITAL STATUS:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
<b>SOCIAL SECURITY NO.</b>		<b>PREFERRED LANGUAGE:</b> <input type="checkbox"/> English <input type="checkbox"/> Other <input type="checkbox"/> Indian <input type="checkbox"/> Spanish <input type="checkbox"/> Russian		
<b>RACE:</b> <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		<b>ETHNICITY:</b> <input type="checkbox"/> Hispanic or Latin <input type="checkbox"/> Not Hispanic or Latin <input type="checkbox"/> Refuse to Report		
<b>HOME ADDRESS:</b>		<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<b>HOME PHONE:</b>	<b>CELL:</b>	<b>EMAIL:</b>		
<b>EMPLOYER:</b>		<b>WORK PHONE:</b>		
<b>ALLERGIES (Medical Alert):</b>				
<b>Pharmacy:</b>				
<b>PRIMARY CARE PHYSICIAN:</b>		<b>PHONE:</b>	<b>REFERRING PHYSICIAN:</b>	
<b>Pending Legal Issues (arrest, probation)</b>				
<b>Small Detail of what brings you to the Office:</b>				
<b>IN CASE OF EMERGENCY CONTACT</b>				
<b>FIRST NAME:</b>	<b>LAST NAME:</b>	<b>RELATION:</b>	<b>PHONE:</b>	
<b>INSURANCE INFORMATION: PRIMARY</b>				
<b>Insured Name:</b>		<b>Relationship to Patient:</b>		<b>DOB:</b>
<b>Insurance Company:</b>				
<b>Insurance Company Address:</b>				
<b>City:</b>	<b>State:</b>	<b>ZIP:</b>	<b>Phone:</b>	
<b>Policy No:</b>	<b>Group No:</b>		<b>Employer:</b>	
<b>INSURANCE INFORMATION: SECONDARY</b>				
<b>Insured Name:</b>		<b>Relationship to Patient:</b>		<b>DOB:</b>
<b>Insurance Company:</b>				
<b>Insurance Company Address:</b>				
<b>City:</b>	<b>State:</b>	<b>ZIP:</b>	<b>Phone:</b>	
<b>Policy No:</b>	<b>Group No:</b>		<b>Employer:</b>	
<p><b>STATEMENT OF FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFIT:</b> 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. <b>I give permission to leave phone message(s):</b> <input type="checkbox"/> YES <input type="checkbox"/> NO</p>				
<hr/> Patient Signature and/or Guardian				<hr/> Date