Adult Contact Information

WPCS WESTERN PSYCHOLOGICAL & COUNSELING SERVICES, P.C.

Name: ____ Date: ____________________
Address: ____ Gender: M F Age: ______
City: __________________ State: ______ Zip: _________ Date of Birth: _____________
Social Security #: _________ - _________ - _________

Insurance Information

Health Insurance Company:___________________________ Subscriber Name: _______________________
ID number:___________________________ Group/Policy #: _______________________

Contact Telephone Numbers

Please complete relevant information and indicate the number at which you wish to be contacted first.

PHONE NUMBERS	OK to leave messages? Yes	No	Primary contact number?
HOME: ( ) ________________________	☐	☐	☐
WORK: ( ) ________________________	☐	☐	☐
CELL: ( ) ________________________	☐	☐	☐

Marital Status

☐ Single ☐ Divorced (____ years) ☐ Living as Married (_____ years)
☐ Married (_____ years) ☐ Separated (_____ years) ☐ Widowed (_____ years)

Spouse's/Partner's Name: ____
If WPCS is unable to reach you, is it OK to contact your spouse/partner? Yes ☐ No ☐
If yes, spouse's/partner's phone number: **(** **)** ________________________

Employment Status

Are you employed? ☐ Yes ☐ No

Employer Name**:** ____

Emergency Contact Information

Name: ____
Address: ____
Phone: **(** **)** ________________________ Relationship to you: ______________________

Primary Care Physician & Medical Care

Current Physician: ____
Physician Address: ____
PCP Phone #: **(** **)** ____________________ Fax #: **(** **)** ___________________
Emergency Resources
Medical: ________________________________ Dental: ______________________________

Referent

By whom were you referred?____