COUNSELINGBYBONNIE BONNIE K. SHINHEARL LICENSED PROFESSIONAL CLINICAL COUNSELOR

NEW OR RETURNING PATIENT

NAME_____

(last) (first) (middle initial)

NAME OF PARENT/GUARDIAN(if under 18 years):

_____

(last) (first) (middle initial)

ADDRESS_____

_____

(city) (state) (zip)

Birth Date:_____/_____/_____Age:_____Gender:_____F____M

Marital Status:_____

Education Level_____

Who makes up your household?

Name	Age	Relationship	School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOME PHONE (_____)_____Other (_____)_____

PERMISSION TO LEAVE A MESSAGE? YES NO

E-MAIL:_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY_____

ID#_____GROUP#_____

EMPLOYER_____

PARENT/GUARDIAN _____PHONE_____

PARENT ADDRESS_____

GUARANTOR/RESPONSIBLE PARTY

NAME (PLEASE PRINT)_____

SIGNATURE_____DATE_____

SELF-PAY

GUARANTOR/RESPONSIBLE PARTY IS RESPONSIBLE FOR SELF-PAY FEE OF $100.00 AT THE TIME OF SERVICE.

SIGNATURE_____