CONTACT INFORMATION FORM

This information is essential for my records. Please write or print neatly. If any part of this sheet is unclear or does not apply to you, please leave the answer blank.

REGISTRATION INFORMATION:

Name: _____ Date of Birth: _____

Home phone number: _____ Answering machine? Y N

Cell phone number: _____ Answering machine? Y N

Email address: _____ (forms and/or appointments)

Home Mailing Address:

_____

_____

_____

Emergency Contact:

Name: _____

Relationship: _____

Phone number: _____

Would you like our Office Administrator to give you a call (appointment reminder) a day or two before your appointment? Y N

Phone number to leave the message: _____

REFERRING INFORMATION:

Referral Source (name & fax): _____

PERSONAL HEALTH INFORMATION

Family Physician: _____ Can I contact him/her? Y N
Phone: _____

Psychiatrist: _____ Can I contact him/her? Y N
Phone: _____

Other health professional: _____ Can I contact him/her? Y N
Phone: _____

Other health professional: _____ Can I contact him/her? Y N
Phone: _____

Accessibility counselor: _____ Can I contact him/her? Y N
Email / Phone: _____

Teacher: _____ Can I contact him/her? Y N
Phone: _____ Email: _____

INSURANCE INFORMATION (when applicable):

Name of insured person: _____

Insurance company: _____

Subscriber ID: _____ Group Number: _____

Filled by: _____ Date: _____

Relation to client: _____