SOUTHEAST FAMILY COUNSELING

6436 S. Quebec Street
Englewood, Colorado 80111

Dx Code:_____

PATIENT INFORMATION

Patient Name: _____Date of Birth:_____ Sex: M F

Social Security #_____ Marital Status: S M Sep D W Spouse Name:_____

Street Address:_____ City: _____

State:_____ Zip: _____Home Phone:_____ Cell:_____

Email address:_____

PCP Name:_____ PCP Phone:_____

PCP Address:_____ City:_____ Zip:_____

Patient Employer:_____ Work Phone:_____

Employer's Address:_____City:_____

Emergency Contact:_____Relationship:_____Phone:_____

Nearest Relative:_____
(not living with you) (Name, Address & Phone)

RESPONSIBLE PARTY INFORMATION

Name:_____Relationship to Patient:_____

Address:_____City:_____State:_____Zip:_____

Home #:_____Work #:_____Employer:_____

INSURANCE INFORMATION

(Please state if insurance is HMO, PPO, or case management if applicable)

Primary Insurance Information:

Policy Holder:_____D.O.B._____Relationship to Patient:_____

Policy Holder's Social Security #:_____Employer:_____

Insurance Company Name:_____Insurance Phone:_____

Policy or ID #:_____Group #:_____

Secondary Insurance Information:

Policy Holder: _____D.O.B._____Relationship to Patient:_____

Policy Holder's Social Security #:_____Employer:_____

Insurance Company Name:_____Insurance Phone:_____

Policy or ID #:_____Group #:_____