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101 N Lynnhaven Rd, Suite 103
Virginia Beach, VA 23452

PATIENT INFORMATION

Date: _____ Patient: _____ NEW PATIENT UPDATE

LAST FIRST MI PREFERRED TITLE
 MALE FEMALE SINGLE MARRIED DIVORCED WIDOWED

Patient Date of Birth: _____ Patient SSN: _____

Address: _____
ADDRESS LINE 1
ADDRESS LINE 2
CITY ST ZIP CODE

E-Mail: _____ HOME: _____
CELL: _____
OTHER: _____
PAGER: _____
FAX: _____

Referral? Yes No Referred by: _____

Spouse's Name: _____ DOB: _____ Social Security #: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP Tel: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____
Address: _____
CITY ST ZIP CODE

WORK: _____ X
FAX: _____

E-Mail: _____

INSURANCE INFORMATION

Subscriber: _____
Subscriber Date of Birth: _____ Subscriber SSN: _____
Subscriber Employer: _____
Patient Relationship to Subscriber: SELF SPOUSE CHILD OTHER

PRIMARY INSURANCE CARRIER:
Group/Policy No.: _____ ID No.: _____
Address: _____ TEL: _____
TOLL-FREE: _____
CITY ST ZIP CODE FAX: _____

SECONDARY INSURANCE CARRIER:
Group/Policy No.: _____ ID No.: _____
Address: _____ TEL: _____
TOLL-FREE: _____
CITY ST ZIP CODE FAX: _____