VICTORIA HAAG, RN, MS, LCMFT

Find Direction for Your Life . . .

TODAY'S DATE _____/_____/_____

IDENTIFICATION

Patient's Name:_____ DOB_____ Age_____

Patient's Nicknames or Aliases_____

Home Street Address_____ Apt #_____

City_____ State_____ Zip_____

Home Phone_____ Messages may be left at this number Yes No

Work Phone_____ Messages may be left at this number Yes No

Cell Phone_____ Messages may be left at this number Yes No

Email_____@_____ Messages may be sent to this address Yes No

CURRENT EMPLOYER

If student, school attended_____

Name_____

SPOUSE / SIGNIFICANT OTHER or PARENT

Name_____ DOB_____ Age_____

Employer_____ Address_____

EMERGENCY CONTACT PERSON

Name_____ Phone_____

Address_____

REFERRED BY:

Name_____ Address_____

FINANCIALLY RESPONSIBLE PERSON (if other than patient)

Name_____ DOB_____

Address_____ Phone_____

Employer_____

Relationship to Patient_____

PRIMARY INSURANCE *Need copy of card!*

Insurance Company_____ ID#_____ Group_____

Policy Holder_____ DOB_____ Employer_____

Address, if other than patient _____ Phone _____

Relationship to Patient_____

OTHER INSURANCE *Need copy of card!* ☐ I/We have no other insurance

Insurance Company_____ ID#_____ Group_____

Policy Holder_____ DOB_____ Employer_____

Address, if other than patient _____ Phone _____

Relationship to Patient_____

The above information is true and accurate. If any of the information changes, I will immediately notify my therapist

Signature_____