Coastal Counseling Center, PC
Patient Information

Patient Name:_____ **Soc Sec#**_____
Last First Mid. Init.

Address:_____ **City:**_____ **State:**_____**Zip:**_____

Date of Birth:_____ /_____ /_____ **Age:**_____ **Sex:**_____ **Marital Status:**_____

Phones: (H) _____ **(W)** _____ **(C)** _____

Email:_____ **Referred By:**_____

Employer (or School) Name _____ **Phone**_____

Employer (School) Address _____**City**_____**St**_____**Zip**_____

Emergency Contact Name _____**Phone**_____

Emergency Contact Address _____**City**_____**St**_____**Zip**_____

Responsible Party Information *(if different from patient)*

Name:_____ **Soc Sec #**_____
Last First Mid. Init.

Address_____**City**_____**State**_____**Zip**_____

Phones: (H) _____ **(W)** _____ **(C)**_____

Insurance Information

***PRIMARY INSURANCE CO*:**_____ **Identification #**_____

Policy/Group #_____ **Phone# (Provider Services)**_____

Insured's Name_____ **Date of Birth:**_____

Address_____**City**_____**St**_____**Zip**_____

Insured's Soc Sec #_____ **Rel to Pt**_____

Insured Employer Name _____ **Phone**_____

***SECONDARY INSURANCE CO*:**_____ **Identification #**_____

Policy/Group #_____ **Phone# (Provider Services)**_____

Insured's Name_____ **Date of Birth:**_____

Address_____**City**_____**St**_____**Zip**_____

Insured Soc Sec #_____ **Rel to Pt**_____

Insured Employer Name _____**Phone**_____