AFFILIATED FAMILY COUNSELORS

Date: _____/_____/_____ Preferred First Name: _____ Age: _____ Sex: M / F / Trans / Other

PATIENT INFORMATION

Social Security # _____ **Date of Birth**: _____/_____/_____ **Marital Status** M / S / D / W

(Legal) First Name: _____ Last Name: _____ MI_____

Street Address: _____ Apt / Unit: _____

City: _____ State: ____ Zip: _____ Email: _____

Land Line Phone _____ Cell Phone _____ Work _____

Other Phone (please specify details and/or organization): _____

Preferred way to contact you: Land Line / Cell / Work / Other _____

Would you like TEXT appointment reminders? (circle) YES

EMERGENCY CONTACT

First Name: _____ Last Name: _____ Relationship: _____

Phone Number: _____

- I give authorization for AFC to share my protected health information with this person. (circle) YES

RESPONSIBLE PARTY (if different)

Date of Birth (required): _____/_____/_____ **SS #** _____ **Marital Status** M / S / D / W

First Name: _____ Last Name: _____ Relationship: _____

Is the following information the same as Patient above? (circle) YES

Full Address: _____

Land Line _____ Cell Phone _____ Work Phone _____

- If responsible party is DPOA or Guardian, please provide a copy of paperwork. (circle) PROVIDED

PAYMENT	√	INSURANCE COMPANY	NAME of POLICY HOLDER (if different)	RELATIONSHIP	BIRTH DATE
Primary Ins.					
Secondary Ins.					
Self-Pay					

How did you hear about us? _____

Allergies? _____

Check/Fill in all that apply:

- ☐ Never smoke
- ☐ Former smoker
- ☐ Smoke sometimes
- ☐ Every day smoker
- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian / Pacific Islander
- ☐ White / Caucasian
- ☐ Hispanic / Latino
- ☐ Prefer Not to Say
- ☐ Language?_____