Date ____________________
ID Verified ________________
Insurance Card Copied ________
(Staff Use Only)

Pipeline To God Counseling (PTGC)

PATIENT INFORMATION FORM

Patient Name ______________________________ ______/______/__________
SSN

DOB ___/___/_____ **Age** ______ **Email** ______________________________

Address ______________________________ ______________ ____ ________
Street City State Zip

Phone ________________ ________________ ________________________
Home Cell Work
Please note * which is your preferred phone number

Marital Status _______ **Male** ____ **Female**____

Parent or Guardian ______________________________ **Phone** ______________
(If Applicable) (Preferred Phone Number)

Employer or School ____

Emergency Contact ______________ ______________ **Relation to Patient** __________
Name Phone Number

Insurance Company____

Name of Policy Holder _________________________**Policy Holder DOB** ___/___/___

SSN of Policy Holder _____/____/_______ **Relation to Patient** ____________________

Member I.D./Subscriber # ________________________ **Group #** _______________

Employer (Policy Holder) ____

How did you hear about us or find us?

____

May we contact the person who referred you to this office? _________Yes ________No

____
Name of Person Making Referral and Phone Number

May we have your permission to contact you via phone, email or text to remind you of an upcoming appointment? ________Yes ________No