LUSH FAMILIES AND COUPLES
ADULT PATIENT INFORMATION

Date_____ Social Security #_____

Name_____

Address_____

City_____State____Zip_____

Email_____

Phone—Home_____ Cell_____

Gender M F Age____ Birthdate _____ Single

Married Divorced

Occupation_____

Employer_____

Spouse & Children_____

Emergency Contact_____

Relationship_____ Phone_____

INSURANCE Who is responsible for this

account? Myself or…

Name_____

Birthdate _____ Social Security #_____

Coverage by another insurance company? Second

insurer_____

Insurance Assignment and Release

I certify that I have insurance coverage with the company(ies) named above, and assign directly to LUSH Families and Couples all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. LUSH Families and Couples may use my health care/insurance information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment is completed or one year from the last date of service.

X_____ Date_____
BENEFICIARY/GUARDIAN/GUARANTOR

MEDICAL HISTORY

ADHD	AIDS/HIV	Alcohol Abuse
Anemia	Anxiety	Asthma
Bipolar	Cancer	Chest pain
Depression	Diabetes	Drug abuse
Eating issues	Epilepsy	Fibromyalgia
Headaches	Heart Disease	Kidney disease
Liver disease	Schizophrenia	Sleep issues
Stroke	Thyroid issues	Weight loss

Do you smoke?	No	Yes
Do you drink?	No	Yes
Use drugs?	No	Yes
Hospitalized?	No	Yes

Ever physically abused? No Yes
Ever sexually abused? No Yes
Ever emotionally abused? No Yes
Suicidal thoughts? No Yes
Suicide attempt(s)? No Yes
Sexual issues? No Yes

HEALTH CARE PROVIDER AND MEDICATIONS

Physician_____

City_____ Specialty_____

Under doctor's care now? No Yes

Reason_____

Medications and dosage you are taking now

Allergies to medication? None

Prior counseling? No Yes

What is the reason for your visit today?

Who may we thank for referring you?_____
To the best of my knowledge, my intake information is complete and accurate. I understand that it is my responsibility to inform my provider of any change in my insurance or health.

X_____Date_____