Miriam Vinton LPC

1049 Robertson Street #2
Fort Collins, Colorado 80524

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Patient Information (Confidential)

Patient's Name__________________________________

Address __________________________________

City __________________ **State** _______ ***Zip*** _______

Home Phone __________________________________

Cell Phone __________________________________

Work Phone __________________________________

Email Address __________________________________

Patient's Birthdate ______________________________

Patient's SSN __________________________________

Employer __________________________________

Occupation __________________________________

EMERGENCY Contact __________________________

Phone ________________ **Relationship** ____________

Primary Care Physician __________________________

Referred By __________________________________

*****For marriage counseling, you MUST list your spouse*****

Patient's Name__________________________________

Birthdate _______________ **SSN** _________________

IF PATIENT IS A MINOR

Mom's Name__________________________________

Address __________________________________

City __________________ **State** _______ ***Zip*** _______

Mom's Phone # ______________________________

Dad's Name __________________________________

Address __________________________________

City __________________ **State** _______ ***Zip*** _______

Dad's Phone # ______________________________

Responsible Party

DO YOU HAVE MAJOR MEDICAL INSURANCE?

___ Yes ___ No – *Payment is expected in full today*

Insurance Co. Name ____________________________

Insurance ID # __________________________________

Insurance Group # ______________________________

Name of Policyholder ____________________________

Address __________________________________

City __________________ **State** _______ **Zip** _______

Home Phone __________________________________

Work Phone __________________________________

Birthdate ____________ **SSN** ___________________

Employer __________________________________

Relationship to Patient __________________________

DO YOU HAVE SECONDARY INSURANCE?

Insurance Co. Name ____________________________

Insurance ID # __________________________________

Insurance Group # ______________________________

Name of Policyholder ____________________________

Address __________________________________

City __________________ **State** _______ **Zip** _______

Home Phone __________________________________

Birthdate ____________ **SSN** ___________________

Relationship to Patient __________________________

Signature

I acknowledge the above information is true. If the patient is under the age of 18; I hereby give my consent, as legal guardian, for Miriam Vinton, LPC to treat said minor as a client.

Signature __________________________________

Printed Name ______________________________

Date _____________________