Ellen Savage

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Licensed Clinical Professional counselor #27 PO Box 395 Chinook MT 59523 406-262-4242

TODAY's DATE _____20___

Patient's Full Name _____, _____Spouse/parent_____

Street Address _____, City_____, State_____Zip_____

Mailing Address _____

Email address _____@_____.com

Phone numbers (home/cell/work/contact)_____

Patient's Employer, Address & Phone_____

Patient's Date of Birth ___/___/___ Social Security Number (required for billing) ____-___-_____

Who may we thank for referring you to this office? _____

Do you have Medical Insurance Coverage? _____Yes _____No

Are you the primary Insured with this Coverage? _____Yes _____No

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If Patient is not Primary Insured, what is the name of the person who is _____

---Relationship to Patient? _____

---Primary's Person's DOB _____/_____/_____

---Primary's SS# _____-_____-_____ Phone Contact _____

Co-payment, if known $_____._____

EAP Data if applicable _____