Lake City Counseling
2829 Royal Ave. Ste. 200
Madison, WI 53713

INFORMATION SHEET

DATE: ____________

PATIENT'S NAME ____
FIRST INITIAL LAST

PRESENT ADDRESS ____
Street/RFD/Apt/Box

____
City, State and Zip

Home Phone: ________________________ Ok to call (circle one) Yes No

Cell Phone: ________________________ Ok to call (circle one) Yes No

Work Phone: ________________________ Ok to call (circle one) Yes No

EMAIL: ______________________________ Ok to email (circle one) Yes No

MARITAL STATUS: _________ GENDER: _________ AGE:_______ DATE OF BIRTH:___________

INSURANCE OR PAYMENT INFORMATION (PRIMARY)

IF SECONDARY INSURANCE IS AVAILABLE, PLEASE PROVIDE A COPY OF BOTH INSURANCE CARDS

RESPONSIBLE PERSON ____
Name Address Phone

NAME OF EMPLOYER ____

ADDRESS OF EMPLOYER ____

NAME OF INSURANCE CO. ____
Address

PATIENT'S RELATIONSHIP TO RESP. PERSON__________________ RESP. PERSON D.O.B.________________

______________________________ ______________________________
Subscriber or ID Number Group or DIV Number

FAMILY DOCTOR

NAME: ____
CLINIC

ADDRESS: ______________________________ PHONE: ________________

OFFICE SPACE ONLY

______________________________ ______________________________
DATE OF ADMISSION PRIMARY COUNSELOR

____
DIAGNOSIS FOR INSURANCE REPORTING

(Rev.8/18)