Counseling Associates, Inc.
Face Sheet

Patient Information

FOR OFFICE USE ONLY

Patient Name

Case Number

Address

Date　　Fees

City, State, Zip

Therapist

Sex: M F

Date of Birth

Home Phone　　Work Phone　　Mobile Phone　　Email Address

Occupation / Grade　　Employer / School

SSN of Responsible Party　　Referred to us by

Insurance Information

Primary Insurance Company　　Secondary Insurance Company

Subscriber Name　　Subscriber Name

Subscriber Employer　　Subscriber Employer

Patient Relationship to Subscriber: SELF SPOUSE CHILD OTHER　　Patient Relationship to Subscriber: SELF SPOUSE CHILD OTHER

EAP Info:

Additional Information

Spouse / Partner Name　　Date of Birth

Father – if minor　　Date of Birth

Mother – if minor　　Date of Birth

Children / Siblings – names and dates of birth

Emergency Contact Name　　**Relationship**　　**Phone Number/s**

Address　　**City, State, Zip**

Initial Problems and/or Service Request:

FOR OFFICE USE ONLY

Provider Signature　　Diagnostic Term　　Diagnostic Code