Patient Intake Form

1. BACKGROUND INFORMATION

First Name: _____ **Last Name:** _____ **MI:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone No.: _____ [check one] Mobile ☐ / Work ☐ / Home ☐

Email: _____

DOB: _____ **Gender:** [check one] Male ☐ / Female ☐ / Other ☐

2. CREDIT CARD INFORMATION

(If different than patient)

Cardholder Name: _____

Credit Card No.: _____ **Exp.:** ____ / ____ (MM / YY) **CVC:** _____ (3 or 4 digits)

This information is strictly confidential. Your credit card will be charged the contracted rate ONLY in the event of a cancellation without sufficient notice per the Cancellation Policy. In addition, your credit card may be charged for any outstanding balance due that remains unpaid at the end of treatment. Your credit card will not be charged for any other reason without your permission.

3. EMERGENCY CONTACT INFORMATION

In case of emergency, contact:

Full Name: _____ **Relationship:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone No.: _____ [check one] Mobile ☐ / Work ☐ / Home ☐

4. REFERRAL SOURCE

How did you hear about my practice (or from whom)?

ATTENTION: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.