New Patient Forms

Confidential Information

Date: ____/____ /____

PATIENT INFORMATION:

Name:

____DOB:_____/____/____Age:_________

Address:____ City:________________ Zip:________

Home Phone: (____)_______________ Work Phone: (____)_______________ Cell: (____)______________

Where may we leave a message: ____

Sex: M F Marital Status: M S W D E-mail:____

Reason for visit: Individual Couples

Reasons for seeking an appointment:____

____

Referred by:____

RESPONSIBLE PARTY INFORMATION:

Name:____ E-mail:______________________________

Relationship to patient: Self Spouse Other (please indicate): __________________________________

Address:____ City:__________________ Zip:__________

Home Phone: (____)_______________ Work Phone: (____)_______________ Cell: (____)______________

I, the undersigned, accept financial responsibility for payment of all fees at the time of visit, unless other arrangements have been made.

________________________________ ____________________________

Patient's (or responsible party) Signature Date

Tabitha Intschert, L.C.S.W.
21216 Northwest Freeway, # 450
p. (832) 409-3301 f. (832) 237-2676
www.TheHoustonTherapist.com