208 south louise street
glendale, ca 91205
usa
www.cayennewellness.org

PATIENT INFORMATION - ADULT FORM

1. NAME OF PATIENT: ____ **DATE OF BIRTH:** ________________________

SS# OF PATIENT: __________ - ______ - ___________ **DRIVER'S LICENSE NUMBER:** ____________________

2. ADDRESS OF PATIENT: ____

CITY/STATE: ____ **ZIP CODE:** ______________________

3. TELEPHONE NUMBERS AND E-MAIL OF PATIENT:

HOME: ____ *WORK:* ______________________________

CELL: ____________________________________ *PAGER:* ______________________________

EMAIL ADDRESS: ____

4. EMERGENCY CONTACT: ____

FIRST name *LAST Name* *Telephone number*

RELATIONSHIP: _________________________________ *Alternate Telephone Number* _________________________

5. EMPLOYMENT OF PATIENT: *(List name of company and address)*

NAME OF COMPANY: ____

ADDRESS/CITY/STATE/ZIP: ____

EMPLOYMENT STATUS: Full time / Part time / Not employed / Self employed / Retired / Student / Other (please circle)

6. NAME AND ADDRESS OF PERSON CARRYING INSURANCE OR RESPONSIBLE PARTY:

____ ____

Name *Phone numbers*

____

Address *City* *State* *Postal Code*

7. ***NAME OF HEALTH INSURANCE:*** ____

A. *S.S. # OF POLICY HOLDER:* ________ - ____ - ________

B. *DOB OF POLICY HOLDER:* ____________________

C. *POLICY IDENTIFICATION NUMBER* ___________________________ *D. GROUP NUMBER* ________________

8. ***PATIENT REFERRED BY:*** ____ ***CHART NUMBER:*** ____________

PERMISSION TO TREAT

Permission is hereby given to Cayenne Wellness Center and Children's Foundation

to render treatment and/or service to: ____ .

patient's name

Permission is further given for Cayenne Wellness Center and Children's Foundation

to exchange information regarding ____ *with*

patient's name

____

Name of agency

____

Address of agency

____

City, State and Postal Code

____ .

Telephone number of agency

____ .

Contact Name

SIGNATURE OF PATIENT: ____________________________________ *DATE:* ________________

SIGNATURE OF THERAPIST: __________________________________ *DATE:* ________________