Katherine Hannon
Counseling and Coaching, LLC

Confidential

New Patient Information

Date:___________________

Patient Name:____________________________________ SSN:______-_____-________
Last First M.I.

Address:____

City:_________________________________ State:_____________ Zip:________________

Home Phone:(____)_____-________ Work Phone:(____)_____-___________ Ext:________

Cell Phone: (____)_____-_________ E-mail: ______________________________________

Is it OK to call and leave a message at these numbers? ☐ yes ☐ no

Gender: [ ] Male [ ] Female Date of Birth:______-_______-________ Age:_______

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] NA (child)

Employment Status:[ ] Employed [ ] Student [ ] Disabled [ ] Employed/student [ ] Unemployed

Employer (or) School:____

Insurance Company:____

Referral Source:____

Permission to thank referral source? ☐ yes ☐ no

Referral Type: [ ] self [ ] family [ ] spouse [ ] friend [ ] physician [ ] EAP [ ] work
[ ] court [ ] school [ ] internet [ ] other ______________________________

Primary Care Physician (PCP):________________________________Phone:________________

Permission to communicate with PCP about your treatment? ☐ yes ☐ no

<u>In Case of Emergency, Contact:</u>

Name:________________________________ Relationship:_________________________

Phone:________________________________