Arizona Family Resource/Counseling Center
Adult Intake Information

Date: _____

Name:_____ Birth Date:_____ Age:_____

Gender:_____SS #:_____ Marital Status_____

Address:_____ City/State/Zip:_____

Home:_____ Cell:_____ Work:_____

Employer:_____ Occupation:_____

Email Address:_____ Referred by:_____

Emergency Contact Information:

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

Primary Care Physician Information:

Name:_____ Phone_____

Last seen by Physician: Month/Year:_____ For:_____

Current Medical Conditions:_____

Current Medications/dosages:_____

Insurance Information:

Name of Policy Holder:_____

Policy Holder Birthdate:_____ Policy Holder SS #:_____

Employer:_____ Insurance Carrier:_____

ID#:_____ Ins Carrier PH#:_____

Address of Insurance Carrier:_____

----------INTERNAL OFFICE USE ONLY----------

PROVIDER:_____ DX:_____