ADULT INFORMATION FORM
LIFESTANCE HEALTH INC.

Name: _____ Date: _____
Address: _____ Gender: ___
_____ Date of Birth: ___/___/_____
City: _____ State: _____ Zip: _____

Insurance information: _____

CONTACT TELEPHONE NUMBERS

Please complete relevant information and indicate the number at which you wish to be contacted first.

PHONE NUMBERS	**OK to leave Messages?** YES NO	**Primary contact number?**
HOME: ( ) _____	___ ___	___
WORK: ( ) _____	___ ___	___
CELL: ( ) _____	___ ___	___

MARITAL STATUS

___ SINGLE ___DIVORCED (___) YRS ___ LIVING AS MARRIED (___) YRS
___MARRIED (___) YRS ___SEPARATED (___) YRS ___WIDOWED (___) YRS

SPOUSE/PARTNER NAME: _____

If WPCS is unable to reach you, is it OK to contact your spouse/partner? Yes___ No___
If yes, spouse/partner phone number: ( ) _____

EMPLOYMENT STATUS

Are you employed: ___ Yes ___No
Employer Name: _____

EMERGENCY CONTACT INFORMATION

Name: _____
Address: _____
Phone: ( ) _____ Relationship to you: _____
Emergency Dental resource: _____
Emergency Medical resource:_____

PRIMARY CARE PROVIDER

Current Provider: _____Provider Group: _____
Physician Address: _____
Physician Phone Number: ( ) _____
Physician Fax Number: ( ) _____

REFERENT INFORMATION

BY WHOM WERE YOU REFERRED? _____
PHONE: ( ) _____ FAX: ( ) _____

PRESENTING PROBLEM:

_____
_____
_____