

Gold Circle Counseling

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FOR OFFICE USE ONLY:

Date: _____
Provider: _____
DX Code: _____
Freedom #: _____

PATIENT INFORMATION:

Legal First Name: _____
Middle Initial: _____
Legal Last Name: _____
Also known as: _____
Address: _____

Zip Code: _____

Date of Birth: ___-___-_____ Age: _____
Gender: M / F

Social Security number:
(Required to file Insurance) _____-_____-_____

Home/Primary Phone: _____ Is it OK to leave a message at this number? Y / N

Cell/ Alternate Phone: _____ Is it OK to leave a message at this number? Y / N

Work Phone: _____ Is it OK to leave a message at this number? Y / N

E-mail: _____

Emergency Contact:

Relationship: _____
Name: _____
Telephone Number: _____
Alternate Number: _____

Financially Responsible Party:

(Person who receives statements)

Legal First Name: _____
Middle Initial: _____
Legal Last Name: _____
AKA: _____ Relationship to Client: _____
Address: _____

Zip Code: _____

Date of Birth: ___-___-_____ Gender: M / F

Social Security number: _____-_____-_____

Primary Phone Number: _____

Secondary Phone Number: _____

INSURANCE COMPANY: _____

Primary Card Holder: _____

DOB: _____ SSN: _____

Policy or Subscriber ID #: _____

Group # (if any): _____ **EMPLOYER:** _____

PH # on back of card-For Providers: _____

IF CLIENT YOUNGER THAN 19 YEARS OLD: Parent's Name(s): _____

If parents are separated/divorced, who is the custodial parent? Or check here if joint custody ()

Name: _____ Phone Number: _____

Address if not same as the client: _____ City/State/Zip: _____

REFERRAL: Who referred you to Gold Circle Counseling, LLC? _____

May we thank who referred you? If yes, please initial here: _____