GROWTH OPPORTUNITY CENTER PATIENT INFORMATION FORM

Please complete this form so that we can complete your file with necessary information and signatures

Name: ___________________________________ Gender: _______________ Date of Birth __________

Address: _____________________________ City/Town: __________________ State: _____ Zip: _______

Cell: ______________________ Home Phone: _____________________ Work: _____________________

Note: If you would like for us to be able to leave you a voicemail message or contacted by email, please complete the following:

I give permission for Growth Opportunity Center to leave a message for me at the following phone (s):

☐Cell ☐Home ☐Work Signature: _____________________________________ Date: ___________

I give permission for Growth Opportunity Center email me at the following email address (s):

Email:________________________________ Signature: _____________________________Date: _______

Please briefly describe reason for seeking treatment: ____

____

Referred by: ☐Insurance company ☐GOC web site ☐Friend

☐Physician____________________________________ ☐Other___________________________
(Name or Practice Name) (Please Specify)

Emergency Contact: (Name) _________________________________ (phone)______________________

(relationship to patient) _______________________________________

Please note that we will not contact this person except in the case of emergency as detailed in our Informed Consent document.

Party Responsible for Payment: (*If self, check here* ☐ *If other person, complete below*)

Name: ____ Relationship to Patient: ____________________

If contact information is not same as patient, please complete below:

Address: _____________________________ City/Town: _________________ State: ____ Zip: _________

Cell: ______________________ Home Phone: _____________________

Below to be completed by Therapist:

Insurance card checked: □ yes □ no
Type of ID checked: □ driver's license □ other _________________________