



Name: _____ Date: _____

Date of Birth: _____

Street Address: _____

City: _____ Zip Code: _____

Email Address: _____ May I send messages here? **Yes/No**

Contact number: _____ May I leave a message here? **Yes/No**

Insurance Provider: _____

Policy Holder: _____ Relationship: _____

Policy Holder DOB (if different from above) _____

Policy #: _____ Group #: _____

Current Marital Status:

Single _____ Engaged _____ Partnered _____ Married _____
Separated _____ Divorced _____ Widowed _____

Are you currently taking any medications/supplements? **Yes/No**

If yes, please list here:

Significant/Emergency Contact (**Please complete ROIs for each**):

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

How did you hear about Optimal Behavioral Health PLLC?

If referred, do I have your permission to thank them? **Yes/No**

