Jill K. Dodge, LCSW

Individual, marital and Family therapy • Consulting

3990 Old Town Ave., Suite 209A

San Diego, California 92110

(619) 615-5065

CONFIDENTIAL PERSONAL INFORMATION (Please Print)

Today's Date _____ Home Phone _____

Patient's Name_____ Sex: □ Male □ Female

Street Address_____ Age _____

City _____ State _____ Zip _____

Social Security # _____ Driver's License #_____ Birth Date _____

Place of birth (City/State/Country) _____

Occupation_____Business Phone _____

Your Employer _____

Employer's address_____

City_____State _____Zip_____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Spouse Name (or responsible party) _____ Relationship _____

Spouse occupation _____Business Phone _____

Spouse employer _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

In case of an emergency, please notify _____ Relationship _____

Address _____ Phone _____

Family physician's name _____

Address _____ Phone _____

Reffered by _____

AUTHORIZATION TO TREAT:

I authorize and direct Jill K. Dodge, L.C.S.W., to perform such therapeutic procedures that her provider's professional judgment may indicate to be advisable for the well being of myself, my child and/or my family. I understand that no warranty or guarantee is made as to the results of this treatment. I also understand that most insurance companies do no pay for missed appointments, and I agree to assume financial responsibility for the regular fee charged for a failed appointment cancelled with less than 24 hours notice.

Date_____ Signed _____

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or health benefits, to include major medical benefits to which I am entitled, including Champus, and other government sponsored programs, private insurance, and any other health plans to **Jill K. Dodge, L.C.S.W.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. I agree to pay any balance not covered by insurance payments.

Date _____ Signed _____

PLEASE GO TO THE NEXT PAGE AND COMPLETE

Childrens Name Sex Birthdate

_____

_____

_____

_____

Have you ever had counseling or psychotherapy? □ Yes □ No

If yes, list previous therapists, addresses and dates: _____

_____

Please describe briefly the major problem or situation that has caused you to seek treatment at this time.

_____

_____

Do you now take any prescribed medications? □ Yes □ No If yes, please list:

_____

Do you now take any over-the-counter medications? □ Yes □ No If yes, please list:

_____

Do you have any allergies? □ Yes □ No If yes, please list:

_____

Do you, even occasionally, use: □ Alcohol □ Caffeine □ Marijuana □ Nicotine □ Cocaine □ Other _____

Please list any family members who are, or have been, possible substance abusers _____

_____

Please describe briefly the goals you have for counseling. `_____

_____

Is there any other information that I should know? _____

_____

_____

I was referred by _____ Phone _____

Relationship to You _____

Total family annual (or monthly) gross income (include ALL sources): $ _____

If you are covered by any insurance plan please download, print and complete the form **INSURANCE VERIFICATION**.