James M. Mours, L.L.C.

Adult Contact Information

Name: _____ Date: _____

Legal Name (if different): _____

Address: _____ Gender: Male / Female

City: _____ State: _____ Zip: _____ Date of Birth: _____

CELL phone #: _____

HOME phone #: _____

WORK phone #: _____

Primary Phone # = Cell : Home : Work Messages OK? Yes : No ?

Insurance Information

Primary Health Insurance: _____ Subscriber Name: _____

Relationship to Subscriber: _____ Subscriber Date of Birth: _____

ID number: _____ Group/Policy #:_____

Additional Health Insurance:_____ Subscriber Name: _____

Relationship to Subscriber: _____ Subscriber Date of Birth: _____

ID number: _____ Group/Policy #: _____

Are you utilizing an Employee Assistance Program (EAP)? _____

Emergency Contact Information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____

Address: _____

Phone: (____) _____ Relationship to you: _____

Primary Care Physician

Current Physician: _____

Physician Address: _____

Physician Phone Number: (____)_____

Physician Fax Number: (____) _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

~ If Yes, please fill out a Release of Information form.