GREATER BALTIMORE
COUNSELING CENTER, LLC

Glen Burnie • Odenton • Timonium
ph 410.760.9079 • fax 410.760.1121

Please fill out this information to the best of your knowledge. Only patient information is to go in patient sections of the form (if the patient has no social security or license, do not fill in). Please make sure you present your insurance card and driver's license to a staff member to receive a copy at this time.
** Note: The demographic information listed on your insurance card/ID will be listed on your medical record and used for billing purposes. Please feel free to discuss with staff should you have any questions.

Today's Date: _____

Patient Information:

Legal Last Name:_____ Legal First Name:_____

M.I._____

Prefered/commonly used name_____

Home Address:_____

City: _____ State:_____ Zip Code:_____

Home Phone #: (____)_____-_____ Mobile # (____) _____-_____

Birth Date: _____Age:_____Social Security #:_____

Driver's License #: _____

Relationship Status: Single___ Partnered___ Married___ Separated___ Widowed___ Divorced ___Other___

Employer/School:_____ Occupation:_____

Work Address:_____

Work Phone #: ( ) _____-_____ (Ext.):_____Email Address:_____

Who may we thank for referring you?_____

Parent/Guardian Information:

Legal last name:_____ Legal first name:_____ M.I.____

Preferred/commonly used first name:_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: ( )_____-_____ Birth Date_____ Age:_____

Social Security #: _____Drivers License #: _____

Employer: _____ Occupation: _____

Work Address: _____

Work Phone Number: ( ) _____-_____ (Ext.):_____ Email Address: _____

(Please complete both sides)

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Primary Insurance Coverage:

Insurance Company: _____ Policyholder: _____

Membership Number: _____ Group Number_____

Policy Holders Date of Birth: _____ Insured's Relationship to client: _____

Effective Date: _____ Employer of Policyholder: _____

Sex Used By Insurance--To Ensure that your Care is Covered this is Required: (circle one) Male Female

Secondary Insurance Coverage:

Insurance Company: _____ Policyholder: _____

Membership Number: _____ Group Number_____

Policy Holders Date of Birth: _____ Insured's Relationship to client: _____

Effective Date: _____ Employer of Policyholder: _____

General Patient Information:

Do you have any medical conditions/allergies that may affect your treatment here? Yes / No

If yes, what reasons? _____

Primary Care Physician Name: _____ Phone Number: (____)_____-_____

Address: _____ City: _____ State:_____ Zip_____

Are you on Medication? _____ If yes what kind? _____

What issues or concerns do you have which made you decide to seek help? _____

_____.

Have you ever had therapy or counseling before? _____

Facility/Therapist Name: _____ Phone Number: _____

For what reasons? _____

In case of an emergency, who should be contacted? Name: _____

Relation:_____ Phone Number: ( ) _____-_____

Complete the chart below listing each member of your household by name, age, and relation.

Name	Age	Relationship