

**ADULT INFORMATION FORM
LIFESTANCE HEALTH INC.**

Name: _____

Date: _____

Address: _____

Gender: _____

Date of Birth: ___/___/___

City: _____ State: _____ Zip: _____

Insurance information: _____

CONTACT TELEPHONE NUMBERS

Please complete relevant information and indicate the number at which you wish to be contacted first.

PHONE NUMBERS

OK to leave
Messages?
YES NO

Primary contact
number?

HOME: () _____

___ ___

WORK: () _____

___ ___

CELL: () _____

___ ___

MARITAL STATUS

___ SINGLE ___ DIVORCED (___) YRS ___ LIVING AS MARRIED (___) YRS

___ MARRIED (___) YRS ___ SEPARATED (___) YRS ___ WIDOWED (___) YRS

SPOUSE/PARTNER NAME: _____

If WPCS is unable to reach you, is it OK to contact your spouse/partner? Yes ___ No ___

If yes, spouse/partner phone number: () _____

EMPLOYMENT STATUS

Are you employed: ___ Yes ___ No

Employer Name: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Address: _____

Phone: () _____

Relationship to you: _____

Emergency Dental resource: _____

Emergency Medical resource: _____

PRIMARY CARE PROVIDER

Current Provider: _____ Provider Group: _____

Physician Address: _____

Physician Phone Number: () _____

Physician Fax Number: () _____

REFERENT INFORMATION

BY WHOM WERE YOU REFERRED? _____

PHONE: () _____ FAX: () _____

PRESENTING PROBLEM:

