

Southern Oregon Counseling

Michael Safko, Psy.D.

Licensed Psychologist (#1870)

777 NE 7th Street, #108

Grants Pass, Oregon 97526

541-471-8840

Date: _____

Name: _____

Age: _____

Date of birth: _____

Home Address: _____

Work phone: _____

City: _____

State: _____

Zip: _____

Home phone _____

Cell phone: _____

SSN: _____

Employer or School _____

Special instructions regarding contacting you at home or at work:

Regarding clients who are under 18 years of age: If you have been granted custody to authorize treatment by a court or other agency, please bring your authorization to your first session.

Do you have any current or recent medical problems?

Are you currently taking any medications (street, over the counter, or prescription drugs):

Yes_____

No_____

If yes, what medications are you taking (including dosage):

Do you have any known allergies: Yes_____

No_____

If yes, please name them:

Have you suffered from any head trauma:

Yes_____

No_____

If yes, please list them:

Name of current physician: _____ Phone: _____

Referred by: _____

May we send a thank you note to your referral source? Yes_____ No_____

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Previous psychological treatment or counseling: Yes____ No____

Name of previous therapist: _____ Phone: _____

Billing Information

Responsible Person: _____ Relationship to client: _____

Address: _____

Home Phone: _____ Work Phone _____ Cell Phone _____

Social Security Number: _____ Date of Birth: _____

Employer: _____ Address: _____

Insurance Information

Primary Insurance Carrier: _____

Name of member/subscriber? _____ Date of Birth _____

Insurance ID # _____ Group # _____

Secondary Insurance Carrier: _____

Who is the member/subscriber? _____ Date of Birth _____

Insurance ID # _____ Group # _____

Signature: _____

Date signed: _____

Signature of Parent or Guardian: _____