Positive Reflections Coaching and Counseling

Today's Date _____ Gender: _____ Date of birth _____

1st Name _____Middle _____Last_____

Cell phone _____ Work phone _____

Address_____City_____

Zip-code_____ Email address_____

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Employer_____Supervisor_____Phone_____

Primary Care Physician _____ Phone _____

Are you married? Y N Name of spouse _____ Phone _____

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Do you permit us to send you email, text messages, and leave voice mail Y N

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Emergency contact_____ Relationship_____

Phone_____ Address _____

email address _____ Date of birth _____

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How did you find us?

Person responsible for payment _____ **Relationship** _____

Address _____

Phones _____

Positive Reflections Coaching and Counseling

Medical Insurance Name _____

Policy Holder Full Name _____

Member ID Number _____ Group Number _____

Date of birth_____SSN_____ All Phones_____

Address_____City_____Zip-code_____

Email address_____Employer_____Phone_____

Relationship to patient _____

PLEASE ATTACH TO TEXT MESSAGE TO 719-647-9930

OR EMAIL TO office@positivereflections.info.