**LOHMAN COUNSELING ASSOCIATES, INC.**
Larry R Lohman MA, LPC
Carolyn J Lohman MA, LPC, LMFT

Date_____

**Patient Information**
Name: ( first ) _____ M.I._____
( last )_____
Date of Birth: _____ Age: _____ Gender: _____
Mailing Address: _____
City: _____ State: _____Zip:_____
Home Phone: _____ Work Phone:_____
Mobile:_____
Employer:_____
Employer's Address: _____
City: _____ State:_____
Zip:_____
Social Security No.:_____
Email: _____
Spouse's name: _____

**Party responsible for payment ( if other than the patient named above )**
Name: _____ Phone: _____
Street Address: _____
City: _____ State: _____ Zip: _____

Drivers License #: _____ Social Security: _____

**Insurance Information**
Policy Holder's Name: _____
Insured's Date of Birth: _____ Insurance ID:_____
Insured's Address: _____
City: _____ State: _____ Zip: _____
Insurance Company: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Group #: _____ Phone: _____
Authorization #: _____ Start Date: _____

**LOHMAN COUNSELING ASSOCIATES, INC.**
Larry R Lohman MA, LPC
Carolyn J Lohman MA, LPC, LMFT

Name of Patient: _____

**In Case of Emergency Contact**: _____
Rel. to patient: _____

Street Address: _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Mobile _____

**Who is your primary care physician?**

_____

Do we have your permission to notify your PCP that you are coming for counseling? _____

Mailing Address: _____
City _____ State _____ Zip _____
Phone _____

Do you see a psychiatrist? Yes _____ No _____

Name of Psychiatrist

_____

Medication allergies

_____

List current medications Dosage Frequency

_____

_____

**Prescribing Physician**

_____

Initial _____