

Heidi Lasser
3709 N. Locust Grove Rd., Ste. 100
Meridian, ID 83646

Patients' Information

Name: _____ Sex: M F Age: _____

Name: _____ Sex: M F Age: _____

Date of Birth: _____ Social Security #: _____

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (home) _____ (cell) _____ (work) _____

***** We call to confirm appointments. Please circle phone numbers that are ok for us to contact you at. May we leave a message? Yes _____ No _____ *****

Employers: _____

Please list all individuals living at home: _____

Medical Information

Family Doctor: _____

Clinic: _____

Please List all medications: _____

How were you referred? _____

Treatment Authorization

Patient Names: _____

(Please print)

I authorize Heidi Lasser, LCPC to provide counseling, payment and healthcare operations for me and my partner. I understand that I may revoke this authorization at any time.

Patient Signature

Date

Patient Signature

Date