**Jennifer Durnell, LMFT, LLC**
**6408 Constitution Drive**
**Fort Wayne, IN 46804**
**Phone: 260/234-1477 Fax: 260/459-0282**

**Patient Name: _____ Gender: __ Male __ Female**

**Address: _____**
**Street/Box# City State Zip**

**Home Phone: _____ Permission to Contact/ Leave Message: __ Yes __ No Initials: _____**

**Work Phone: _____ Permission to Contact/ Leave Message: __ Yes __ No Initials: _____**

**Cellular Phone: _____ Permission to Contact/ Leave Message: __ Yes __ No Initials: _____**

**Marital Status: __ S __ M __ D __ W Patient Employer: _____**

**Patient Date of Birth: _____ Patient Age: _____**

**Primary Care Physician: _____ Permission to Contact Physician: __ Y __ N**

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**Primary Insurance Information**

**Insured's Name (if different from above): _____**

**Insured's Address: _____**
**Street/Box# City State Zip**

**Insured's Social Security #: _____ Insured's Date of Birth: _____**

**Insured's Employer: _____ Relationship to Patient: _____**

**Insurance Company: _____ Insurance ID #: _____ Group # _____**

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**Secondary Insurance Information**

**Insured's Name (if different from above): _____**

**Insured's Address: _____**

**Insured's Social Security #: _____ Insured's Date of Birth: _____**

**Insured's Employer: _____ Relationship to Patient: _____**

**Insurance Company: _____ Insurance ID #: _____ Group # _____**

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**If Child Is Identified Patient/ Client**

**Father's Name: _____ Step Father: _____**

**Mother's Name: _____ Step Mother: _____**

**Emergency Contact**

**Name: _____ Phone: _____ Relationship: _____**