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**PATIENT INFORMATION**

PLEASE COMPLETE THE FOLLOWING:

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

OK TO SEND MAIL TO THIS ADDRESS? YES NO

CITY/STATE/ZIP: \_\_\_\_\_

PRIMARY PHONE: \_\_\_\_\_

OK TO LEAVE MESSAGE AT THIS NUMBER? YES NO

SECONDARY PHONE: \_\_\_\_\_

OK TO LEAVE MESSAGE AT THIS NUMBER? YES NO

E-MAIL: \_\_\_\_\_

OK TO LEAVE MESSAGE VIA EMAIL? YES NO

SOCIAL SECURITY NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

DRIVERS LICENSE: NUMBER \_\_\_\_\_ STATE \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

WILL YOU NEED DOCUMENTATION FOR INSURANCE REIMBURSEMENT? YES \_\_\_\_ NO \_\_\_\_

WHO REFERRED YOU TO THIS OFFICE? \_\_\_\_\_

