Dr. Beau A. Nelson, DBH, LCSW
Doctor of Behavioral Health
Counseling and Psychotherapy

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PATIENT INFORMATION

Please complete the following:

Patient Name: _____

Address: _____

City/State/Zip: _____
Ok to send mail to this address? Yes No

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? _____

For Office Use Only:
New Update: _____
_____
_____
_____