

**Draga Beckner, LCSW**  
**Patient Information**

9111 Broadway, Suite N  
Merrillville, IN 46410

5 Washington Street, Suite 350  
Valparaiso, IN 46383

Legal Name \_\_\_\_\_

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

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

AT WHICH NUMBER DO YOU PREFER TO BE CONTACTED? \_\_\_\_\_

MAY WE LEAVE A MESSAGE? \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX: (PLEASE CHECK) \_\_\_ MALE \_\_\_ FEMALE

MARITAL STATUS \_\_\_\_\_ MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ DIVORCED \_\_\_\_\_ SINGLE \_\_\_\_\_ OTHER

EMPLOYER NAME: \_\_\_\_\_

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

INSURANCE CARRIER: \_\_\_\_\_ INSURANCE ADDRESS \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_ ID NUMBER \_\_\_\_\_

PHONE NUMBER OF INSURANCE: \_\_\_\_\_

**FINANCIAL PARTY INFORMATION**

LEGAL NAME: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS (IF DIFFERENT FROM ABOVE) \_\_\_\_\_

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

EMPLOYER NAME AND ADDRESS \_\_\_\_\_

■ \_\_\_\_\_  
(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY)



