# George Ankuta, Ph.D.

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## ADULT PATIENT INFORMATION FORM

Name: _____Age:_____Date of Birth: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____Cell Phone: _____

email:_____ Work Phone: _____

Occupation: _____ Employer: _____

Marital Status: _____ If Married, Name of Spouse: _____

Occupation of Spouse: _____ Work Phone: _____

Spouse's Employer: _____ Age of Spouse: _____

Names and Ages of Children (place an "x" next to those children living in your home):

_____

Current Physician: _____ Phone: _____

Medications Currently Taken: _____

Previous Therapists/Counselors Seen (please include dates): _____

_____

In case of Emergency; Name and Phone Number of Contact Person: _____

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