

Olympia Center for Dialectical Behavioral Therapy  
Beth Rogers, M.A., L.M.H.C.  
2401 Bristol Ct, Suite C-103  
Olympia, WA 98502

Full Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Were you referred? \_\_\_\_ Yes \_\_\_\_ No If so, by whom? \_\_\_\_\_

In case of emergency call: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Information (please provide a copy of your insurance card at your initial visit)

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Holder/Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Relationship to policy holder: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

If TRICARE, branch: \_\_\_\_\_ If TRICARE, subscriber's SSN: \_\_\_\_\_

Duty Status: \_\_\_\_\_ Rank: \_\_\_\_\_

For Office Use Only: Date of Intake: \_\_\_\_\_ Dx: \_\_\_\_\_