Patient Information

Date________________

Client's First Name ___________________ Last Name _________________ MI ______________
Address ________________ City ______________ State____________ Zip _______________
Telephone (Home) ___________________________ (Work) ______________________________
Birthdate _____/_____/_____ Age ______ Gender _____F _____M Race ___________________
Client's Social Security # __________________
Name of Spouse/Guardian ___________________________ Phone _________________________
Address ______________________ City _______________ State _____________ Zip ________
Person Responsible for Payment _________________________ Soc. Sec. # ___________________
Signature of Person Responsible for Payment X _____________ (Must be signed for services to begin)

EMERGENCY INFORMATION

In case of emergency, contact:
Name (1) __________________ Relationship __________ Phone __________ Work ________
Address __________________ City _________________ State __________ Zip ____________
Name (2) __________________ Relationship __________ Phone __________ Work ________
Address __________________ City _________________ State __________ Zip ____________
Psychiatrist ____ Phone ________________
Address __________________ City _________________ State __________ Zip ____________
Current Medications ____
Allergies ____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place ____________________________ Phone ___________ Hrs __________
Spouse: Place ___________________________________ Phone ___________ Hrs __________

INSURANCE INFORMATION

Primary Insurance _______________________
Phone________________________________
Contract/ID# ___________________________
Group/Acct#___________________________
Subscriber_____________________________
Subscriber Date of Birth__________________
Client's relationship to Subscriber
___Self ___Spouse ___Child ___Other_________

Secondary Insurance ______________________
Phone_________________________________
Contract/ID# ___________________________
Group/Acct# ___________________________
Subscriber _____________________________
Subscriber Date of Birth__________________
Client's relationship to Subscriber
___Self ___Spouse ___Child ____Other________

PROVISIONS: Client pays $____________ Deductible amount Amount satisfied: $______________
Insurance pays__________ % for visits____–____ and__________ % for visits____–____
Type(s) of providers covered: __________________________ Supervision: ____________________
Prior authorization needed: ____
Effective date: ____________________________ Policy anniversary: _______________________
Coverage for testing: _______________________ Annual limit: _____________________________

REFERRAL SOURCE

How did you hear of our clinic (or from whom)? ____
Address ________________________ City _________________ State ________ Zip __________
Phone ________________________ Relationship to referral source _________________________