

Client Name: _____
Street: _____
City: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
County: _____
Additional Client: _____

DOB: _____ Age: _____
Gender: _____
SSN: _____
Marital Status: _____
School: _____
Grade Level: _____
Employer Name: _____
Occupation: _____
Denomination: _____
Church: _____
Race: _____

Assigned Provider: _____ Appointment Date: _____ Time: _____
Location: _____

Name of Referral: _____
Would you give permission for the Center to contact the person who referred you? ____yes ____no
Have you had previous counseling? ____yes ____no
If yes, name of counselor: _____ Date: _____
Physician: _____
Please list current medications: _____
Person to contact in case of emergency: _____
Relationship: _____ Phone Number: _____

I certify that the above information is correct and I understand and accept the policies of the attached letter.

Client Signature

Date

Insurance Information

Insurance Company: _____
Street: _____
City: _____
Phone: _____
Policy Number: _____
Group Number: _____
Policy Effective Date: _____
Authorization #: _____

About the Insured

Name: _____
SSN of Insured: _____
Street (if different from client): _____
City: _____
Phone: _____
D.O.B.: _____
Relationship to client: _____