

Initial Date of Service: \_\_\_\_\_ DX: \_\_\_\_\_

**SECTION I CLIENT INFORMATION**

---

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

May we leave a message?  Yes  No

May we leave a message?  Yes  No

Email (optional)\* \_\_\_\_\_

*\*Please note: Email correspondence is not a confidential medium of communication.*

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Employer or School/Grade \_\_\_\_\_  Employed  F/T Student  P/T Student

Client's Marital Status  Single  Married/Partnered  Separated  Divorced  Widowed

Parents' Marital Status (if applicable)  Single  Married/Partnered  Separated  Divorced  Widowed

Referred by \_\_\_\_\_

Is the client covered by insurance?  Yes- Go to section II

No- Go to section V for responsible party information

**SECTION II INSURED INFORMATION**

---

Relation to client:  Spouse/Partner  Parent  Other  Self – Go to section III

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

May we leave a message?  Yes  No

May we leave a message?  Yes  No

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer or School/Grade \_\_\_\_\_  Employed  F/T Student  P/T Student

**SECTION III INSURANCE POLICY INFORMATION**

---

*If you have provided a copy of the client's insurance card, you do not need to fill in this section.*

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Plan Name \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_

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

Is the patient covered by more than one insurance?  Yes- Go to section IV

No- Go to section V

**SECTION IV SECONDARY INSURANCE INFORMATION**

---

*If you have provided a copy of the client's insurance card, you do not need to fill in this section.*

Insurance Company \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Plan Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

**SECTION V RESPONSIBLE PARTY INFORMATION**

Who is responsible for charges for this patient?  Patient- Please continue to next section  
 Insured- Please continue to next section  
 Other- Please complete the following information

Responsible Person/Agency \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
May we leave a message?  Yes  No May we leave a message?  Yes  No  
Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Employer or School/Grade \_\_\_\_\_  Employed  F/T Student  P/T Student

**SECTION VI PARENT, GUARDIAN, AND FAMILY INFORMATION (If Applicable)**

Parent/Guardian 1	Parent/Guardian 2
Name _____	Name _____
Age _____	Age _____
Occupation _____	Occupation _____
Telephone _____	Telephone _____

Please describe custody arrangements (if applicable): \_\_\_\_\_  
\_\_\_\_\_

Are there other relatives or adults that are important caretakers of your child (i.e. stepparent, significant other, grandparent)? Please list:

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list information about your child's brothers or sisters below (please include stepsiblings):

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____