



# CLIENT INFORMATION SHEET 1/2

The following information is required to properly file Insurance/Funding forms for payment consideration under new Healthcare Reform and Reporting laws. Failure to provide the following information may result in non-payment of your claims. If this occurs, you will be responsible for payment in full. Please fill in all blanks as completely as possible and circle any multiple-choice options.

If patient/client is a child or has a guardian, the parent or guardian should fill in the information below for the patient. If you are the patient and the guarantor, fill out both sections.

Today's Date: \_\_\_\_\_

### Patient Information:

Patient First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip+4: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Group/Nursing Home: Yes \_\_\_\_\_ No \_\_\_\_\_

Phone number: Cell # \_\_\_\_\_ Home # if different: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email: \_\_\_\_\_ Copy of Driver's License/Picture ID \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Domestic Partner \_\_\_\_\_

Gender: Male Female Transgender Gender Fluid Other \_\_\_\_\_

Primary Race: White Black or African American American Indian or Alaskan Native Asian

Native Hawaiian or Other Pacific Islander Other (Specify) \_\_\_\_\_

Secondary Race: White Black or African American American Indian or Alaskan Native Asian

Native Hawaiian or Other Pacific Islander Other (Specify) \_\_\_\_\_

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Student Status: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Non-Student \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Present Problem: \_\_\_\_\_

Previous or Current Treatment: Yes No If yes: Inpatient Outpatient Duration/Dates \_\_\_\_\_

Name of hospital, clinic, or therapist where treated: \_\_\_\_\_

May we contact your previous or current therapist? Yes No Phone Number: \_\_\_\_\_

Reason for treatment: \_\_\_\_\_

Who referred you to The Center: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

May we contact your Primary Care Physician? Yes No

Have you served on active duty in the U.S. Armed Forces, military Reserves, or National Guard? Yes

# CLIENT INFORMATION SHEET 2/2

What is your religious affiliation, if any: \_\_\_\_\_

How does your religious affiliation affect your life: \_\_\_\_\_

Guardian First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
(If different from patient or above information)

Address: \_\_\_\_\_  
(If different from patient or above information)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip+4: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Preferred Language: \_\_\_\_\_  
(if different from patient information)

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(If different from patient or above information) (If different from patient or above information)

Copy of Driver's License/Picture ID: \_\_\_\_\_ (if different from patient)

Patient or Guarantor Information:  
Employment Status: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Not Employed \_\_\_\_\_ Disabled \_\_\_\_\_ Retired \_\_\_\_\_

Employer: \_\_\_\_\_

Employers Phone Number: \_\_\_\_\_ Ext: \_\_\_\_\_

The below person is the emergency contact individual for the patient and can also be allowed to make or verify your appointments and/or communicate with the office about your billing account.

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone \_\_\_\_\_

Insurance:

Payer Name: \_\_\_\_\_ Policy Type: \_\_\_\_\_

Address: \_\_\_\_\_ Member #: \_\_\_\_\_

City/ State/ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Policy Holder:

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Address: \_\_\_\_\_ SS #: \_\_\_\_\_

City/ State/ Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_

I acknowledge the above information to be true and accurate to the best of my knowledge.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_