CLIENT INFORMATION

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.

Are you Financially Responsible for this account: Yes No **(If not please have them fill out a separate form.)**

Today's Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address:
_____

City: _____ State: _____ Zip+4: _____

E-Mail:_____ Preferred Language:_____

Social Security Number: _____ Date of Birth: _____

Driver's License/Picture ID: _____State Issued: _____

Cell Phone: _____ Home Phone: _____

Gender: Male Female

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) _____

Marital Status: Single Married Legally Separated Divorced Widowed Domestic Partner

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Employment Status: Full Time Part Time Not Employed Disabled Retired ____ /Date Retired _____

Employer: _____

Employers Phone Number: _____ Ext: _____

Student Status: Full Time Part Time Non-Student

Emergency Contact Name: _____ Relationship _____

Home Phone _____ Cell Phone _____

Who referred you to The Center: _____

Primary Care Physician: _____ Phone: _____

How will you travel to your appointment: Self/Private Vehicle Walk Cab City Bus

Facility Transportation Family or Friend OATS or Other Subsidized

Family Income: $15,999 or below $16,000 to $19,999 $16,000 to $19,999 $20,000 to $23,999

$24,000 to $27,999 $28,000 to $29,999 $30,000 to $36,999 $37,000 to $39,999

$40,000 to $47,999 $48,000 to $49,999 $50,000 and above

Number of People living in your Home: _____

Have you served on active duty in the U.S. Armed Forces, military Reserves, or National Guard? Yes No

What is your religious affiliation, if any: _____

Present Problem: _____

Previous Treatment: Yes No **If yes:** Inpatient Outpatient Duration/Dates_____

Name of hospital, clinic, or therapist where treated: _____

Reason for treatment: _____

_____

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.

_____ _____

Signature of Client/Guardian **Date**

_____ _____

Printed Name of Client/Guardian **Relationship to Client**

_____

Witness if Client Unable to sign