

Date:_____

First Name:		Mid. Init	Last Name:				
Address:					-		
DOB:SS#		Gender:N	ИF Marital Status:	MarriedSingl	eOthe		
Employment Status:	Employed	Part-time Stud	entFull-time Stud	dentOther			
Employer/School:		Town:_	Jo	ob Title:			
Home #:							
Emergency Contact Na	me & #:						
Primary Care Provider	Name & #:						
Email Address:	Name of Accompanying Adult:						
Referral Source							
Referral type:Insu	rance Web-s	ite Physician	Friend Brochure/Fl	ver Phone Book	Other		
Name of Reference:							
	D.III D.						
Person Responsible fo	r Bills: Primary		DET (If patient is responsible fo				
First Name	Mid. Init.	Last Name		Mobile #:			
Address		Town	State	Zip			
DOB:SS#:		Sex:MF	Patient Relationship	:ChildSpouse	eOther		
Employer Name & #:			Signatur	e:			
Insurance							
Primary Insurance-Plar	n Name						
ID #:	Group#:	 \$	Copav Ś	 Deductible			
	% for visitsEffective Date: Type of Providers Covered:						
Annual Limit:							
					•		
Secondary Insurance-P							
			Copay \$				
		sEffective Date:					
Coverage for Testing:_							
Annual Limit:	Prior Authorization Needed:						
Family Data							
Spouse/Parents:							
	Name	DOB	Occupation	Ethnicity	_Religion		
		DOB		Ethnicity			
Continued on the back					_ •		

Siblings/Children:								
	Name	_DOB	_In home	Relationship to ParentGender				
	Name	_DOB	_In home	Relationship to ParentGender				
	Name	_DOB	_In home	Relationship to ParentGender				
Staff: Record Information								
Tots ID#:	First Steps Service Coordinator:							
First Date Recorded:	Discharged:	C	ut Referred to:_					
Education Materials:	Given to:							
Date Signed: Client's Rights_	Consent to T	reat:	Financial Po	olicy:Record Release				