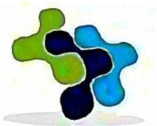


Client Information Form

Date: ___________________

Patient Name: ______________________________________ **SSN:** ______-_____-_______
Last First M.I.

Address: ____

City:___________________________________ **State:** ______________ **Zip:** _________________

Home Phone: (____) _____-_________ **Work Phone:** (____) _____-____________ **Ext** ______

Cell Phone: (____) _____-_________ **Email address:** __________________________________

Gender: [ ] Male [ ] Female Date of Birth: ______-_______-_________ Age: _______

Marital Status: [ ] Married [ ] Single [ ] Divorced
[ ] Separated [ ] Widowed [ ] NA (children)
Employment Status: [ ] employed [ ] student [ ] Retired
[ ] employed/student [ ] unemployed

Employer/ School: ____

How did you hear about us? ____

Referral Type: [ ] self [ ] family [ ] spouse [ ] friend
[ ] clergy [ ] EAP [ ] work [ ] court
[ ] school [ ] other ____

Primary Care Physician: ________________________________ **Phone:** ___________________

In Case of an Emergency, who would you like us to contact?

Name: __________________________________ **Relationship:** ___________________________

Phone: __________________________________

<u>If patient is minor:</u>
[ ] Mother (or Guardian) [ ] Father

Name: _______________________________

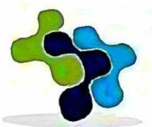
Address: _______________________________

____

(C) Phone: ______________________________

(H) Phone: ______________________________

(W) Phone: _____________________________



Health Insurance Information Form

Please complete this form if you have insurance for which you want Desert Counseling & Recovery Services to bill. Please note that if Desert Counseling & Recovery Services is not contracted with your insurance company, services provided by Desert Counseling & Recovery Services may be considered out of network.

Client/Patient Name: ________________________________ **Date of Birth**_______________ **Male O Female O**

Address: ___________________________________

City State Zip Code: ________________________

Phone #___________________________________ **Health Insurance Name:**	**Insured ID Number:**
Insurance Plan Name:	**Insured Group Number:**
Client Relationship to insured:	Self O Spouse O Child O Other O
Insured's Name: (Last Name, First Name)	**Insured Phone:**
Insured's Address:	**City, State, Zip:**
Insured Date of Birth:	**Male O Female O**
Employer or School Name:	

SECONDARY INSURANCE IF APPLICABLE

Phone #___________________________________ **Health Insurance Name:**	**Insured ID Number:**
Insurance Plan Name:	**Insured Group Number:**
Client Relationship to insured:	Self O Spouse O Child O Other O
Insured's Name: (Last Name, First Name)	**Insured Phone:**
Insured's Address:	**City, State, Zip:**
Insured Date of Birth:	**Male O Female O**
Employer or School Name:	

By signing below, you authorize payment of medical benefits to Desert Counseling & Recovery Services.

X_________________________________ X _________________________________ X ____________________

Signature of Client or Authorized Person **Printed Name** **Date signed**