☐ Portal Access

☐ Emailed

Intake: Please complete this form fully & bring a list of current medications to 1st visit
Photo ID card of client or guardian(s) and insurance card will be copied for office records

Client Name: _____Gender: _____ DOB:____/____/____

Parent/Guardian/Spouse (specify): _____ ☐ divorced

Parent/Guardian/Spouse (specify): _____

Reason for seeking counseling: _____

Address: _____ City: _____

State: _____ Zip: _____ School/Grade: _____

Home Phone: _____ Cell Phone: _____ Do you text? ☐ Yes ☐ No **Access to Computer?** ☐ Yes ☐ No

Okay to leave a msg? ☐ Home ☐ Cell E-mail: _____

Marital Status: _____ Employer: _____

Payment Method: ☐ Insurance ☐ Self Pay Responsible party_____

☐ **Required** Credit Card for no-show: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Exp: _ _/_ _ Code _____ Billing Zip _____

Primary Insurance:_____ ID #: _____

Group #:_____Subscriber Name: _____Co-Pay: _____ Ded: ____

Insurance Subscriber's Address: _____

Insurance Phone for Mental Health:_____ Subscriber DOB:____/____/____

Authorization Number: _____ Dates Authorized: _____

Emergency Contact Name: _____ ER Contact Relationship:_____

Emergency Contact Phone: _____ Is a release on file for this person? Yes No

How were you referred?_____ If online, which website?_____

Primary Care Provider: _____ Fax: _____

Psychiatrist: _____ Last visit: _____

☐ In person (bring mask) requested ☐ Teletherapy request Scheduling requests: _____

For office use: Date and time of Initial phone call/email: _____ Follow-up _____

For office use: Scheduled with: _____ Date/Time: _____

406 McIntosh Avenue Orange Park, FL 32073
(904)375-1243 phone www.escounseling.com