ROAD TO READY COUNSELING, LLC.
7465 Old Hickory Drive STE D Mechanicsville, Virginia 23111
9157 Atlee Road Suite A Mechanicsville, Virginia 23116
Phone: 804-404-8222

DEMOGRAPHIC FORM

CLIENT INFORMATION

Today's Date: ____/_____/_____

Legal First Name: _____

Legal Last Name: _____

Middle Name: _____

What Name do you go by? _____

Email Address: _____

Would you like appointment reminders by email? _____

Phone Number: _____

Is it okay to send voice messages to this number? _____

Is it okay to send text messages to this number? _____

Would you like appointment reminders by text message, voice message, email, or all? _____

Client's Street Address: _____

City: _____ State: _____ Zip Code: _____

Client's Date of Birth: _____/_____/_____

Client's Sex (Female, Male, Prefer Not to Say): _____

Client's Gender Identity (Add your gender identity and pronouns): _____

Guardian Name (if Client is under 18 years old): _____

Guardian's Relationship to Client: _____

Guardian's Phone Number: _____

Guardian's street address if different than the client's address:_____

City: _____ **State:** _____ **Zip Code:** _____

EMERGENCY CONTACT

First Name: _____

Last Name: _____

Relationship to Client (Child, Family Member, Legal Guardian, Physician, Parent, Partner, Spouse, Other):

_____

Email Address of Emergency Contact: _____

Is it Okay to Send Messages to this email?_____

Would you like appointment reminders sent to this email? _____

Phone Number of Emergency Contact: _____

Is it okay to send voice messages to this number? _____

Is it okay to send text messages to this number? _____

Would you like appointment reminders by text message, voice message, email, or all? _____

Insurance Information

PRIMARY HEALTH INSURANCE INFORMATION

Primary Insurance Company: _____

Member ID: _____

Group ID: _____

Plan ID (if applicable): _____

Client's relationship to insured (Client, Client's spouse, Client's Parent, or Other):

_____

Primary Policy Holder DOB: _____/_____/_____

SECONDARY HEALTH INSURANCE INFORMATION

Secondary Insurance Company (if applicable): _____

Member ID: _____

Group ID: _____

Plan ID (if applicable): _____

Client's relationship to secondary insured (Client, Client's spouse, Client's Parent, or Other):

_____

Secondary Policy Holder DOB: _____/_____/_____

- **Please submit a copy of the FRONT and BACK of the client's insurance cards along with all completed forms to admin@roadtoreadycounseling.com**