Request for Service

Request Date:_______________ Screened by:_______________________________________ Date:_________________

Have you ever been seen here in this practice before? No ____Yes ______Year_________

Gender: ☐ M ☐ F ☐ Other, please specify:____

Client Legal Name:____ DOB:_______________ Age:______

Cell#_______________________________ Home#____________________________ Work#_____________________________

Email:____

Referred by:____

Person Calling/Relation:____ Phone#:______________________

Address:____

City/Town:____ State:_________ Zip:________________

Availability for Sessions: ☐ 9am-12pm ☐ 12pm-4pm ☐ 4pm-8pm Day(s) of Week: ___________________________

Primary Insurance:____ID#________________ Group ID#_______________

Client has verified coverage: ___________ deduction amount: ___________ co-pays: ___________
Initial

Secondary Insurance: ____ ID#_______________ Group ID#_______________

Client has verified coverage: ___________ deduction amount: ___________ co-pays: ___________
Initial

Prior Treatment:____

Mental Health Meds?____Diagnosis:_____________________________________

Prescriber: ____ Phone#___________________________

Members of Household

Name	Age	Relationship	Occupation	Concerns

Presenting Problem:____

____

Appt Scheduled – Day/Date/Time: _______________________________________ Clinician:______________________