Client Face Sheet

Date of Intake_____

Name: Last_____ First_____ MI_____

Address_____ City_____ State_____ ZIP_____

Phone: Cell_____ Home:_____ Email_____

May we: Leave voicemail ☐Yes ☐No Send text ☐Yes ☐No Email ☐Yes ☐No

Date of Birth: _____/_____/_____ Age:_____ Sex: ☐Male ☐Female Advanced Directive? ☐Yes ☐No

Social Security #:_____ If client is a minor, do they live in a single parent home? ☐Yes ☐No

INSURANCE

Primary Insurance Carrier	Secondary Insurance Carrier
☐ Commercial Policy ☐ MEDICARE	☐ MEDICAID ☐ Other Commercial Policy
Medicare #: _____	Medicaid # :_____
Commercial Ins:_____	MCO: _____
Policy #:_____	MCO ID: _____
Group ID:_____	Commercial Ins:_____
Policy Holder:_____	Policy #:_____
Policy Holder DOB:_____/_____/_____/	Group ID:_____
Policy Holder Contact Info:_____	Policy Holder:_____
	Policy Holder DOB:_____/_____/_____/
	Policy Holder Contact Info:_____

Financially Responsible Party

Name: _____ Relationship:_____

Address:_____ Date of Birth:_____

City:_____ State:_____ Zip:_____

Employer/School Information

Employer Information	School Information
Name of Employer: _____	Name of School: _____
Work Phone:_____	County:_____
Length of time at position:_____	Phone Number:_____
	Primary Teacher's Name:_____
	Grade:_____ IEP: ☐Yes ☐No

Primary Care Physician

Current Physician: _____ Have you signed a release of information for us to speak to your PCP? ☐Yes ☐No

Physician Address:_____

Physician Phone:_____ Physician Fax:_____

Emergency Contact

Name: _____ Relationship_____

Cell #:_____ Work #_____ Home_____

Signature of Client or Guardian_____