209-A Swanton Way, Suite 102
Decatur GA 30030
678-587-8084

CLIENT INTAKE FORM

Person completing form: **Relationship to client:** **Date: / /**

CLIENT INFORMATION

Client's Last Name First Middle	Student ❑ Yes ❑ No	Name of daycare/school

Is this client's legal name? ❑ Yes ❑ No	If not, what is client's legal name?	(Preferred Name)	Birth Date / /	Age	Sex ❑M ❑ F

Street Address City State	Zip Code	Home Phone No. ( )
P.O. Box City State	Zip Code	Cell Phone No. ( )

Referred to Provider by (Please check one):
❑ Dr. _____ ❑ Insurance Plan ❑ Family ❑ Friend ❑ Other _____

Email Address:	Alternative Email Address:

INSURANCE INFORMATION (PLEASE PROVIDE A COPY OF THE INSURANCE CARD)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Total Annual EAPs allowed? _____

Please select your primary insurance provider:

❑ Magellan Self-pay Other
❑ Aetna
❑ Tricare (**Circle:** Prime / Standard / Reserve Select / Retired Reserve)

What is the authorization number (if applicable)?

Insured's Name	Insured's Phone No.	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Child ❑ Other _____

Name of Secondary Insurance (if any) Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.