CLIENT INFORMATION SHEET

Date: _____
Client's Name: _____ Date of Birth: _____
Home Address: _____ Cell Phone: _____
City: _____ State: _____ Zip: _____
E-mail: _____ Bilingual Needed? ____ yes _____ no
School Attending (if applicable): _____ Grade: _____

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FAMILY/HOUSEHOLD COMPOSITION

Name	Relationship	Age	Other Information

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CONTACT INFORMATION

Parent/Guardian Name: _____ Phone: _____
Employer: _____ Work Phone: _____
Parent/Guardian Name: _____ Phone: _____
Employer: _____ Work Phone: _____
Emergency Contact Name/Relationship: _____ Phone: _____
Referral Source: _____Phone: _____
Primary Care Physician: _____Phone: _____
Other Case Manager: _____Phone: _____
Other: _____Phone: _____

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INSURANCE

Type: _____ Medicaid ____ Private Insurance _____Private Pay Other _____
Insurance Name: _____ Subscriber/Medicaid #: _____
Secondary Insurance: _____ Subscriber #_____

Appointment Cancellation Policy

ALL APPOINTMENTS MUST BE CANCELED 24 HOURS PRIOR TO THE APPOINTMENT WITH THE EXCEPTION OF MEDICAID OR YOU WILL BE BILLED. ARRANGEMENTS CAN BE MADE IN CASE OF EMERGENCIES OR OTHER CIRCUMSTANCES.

_____
Signature Date