



Behavioral Health Clinic Client Information Sheet

Client Information

Last Name:		First:		MI:	Birth Date:	
Address:				City:		State: Zip:
Home Phone:		Work Phone:		Marital Status:	Gender:	Is Client Currently a Student?
				M D S W	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Physician:				Referring Physician:		
Person to Notify in Case of Emergency (friend or relative not living with you):						
<i>Name</i>		<i>Relationship</i>			<i>Phone</i>	
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White						
<input type="checkbox"/> Decline to Answer						
Ethnicity: <input type="checkbox"/> Hispanic/Latino Origin <input type="checkbox"/> Not Hispanic/Latino Origin <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Unknown						

Responsible Party (Legal Guardian)

Spouse/Other Parent

Last Name:		First:	M.I.:	Birth Date:	Last Name:		First:	M.I.:	Birth Date:		
Address:					Address:						
City:			State:	Zip:	City:			State:	Zip:		
Home Phone:		Work Phone:		Cell Phone:	Home Phone:		Work Phone:		Cell Phone:		
E-mail Address:				Relationship to Client:		E-mail Address:				Relationship to Client:	
Circle One:		Employed	Unemployed	Disabled	Retired	Circle One:		Employed	Unemployed	Disabled	Retired
Employer Name:					Employer Name:						
Employer Address:				Phone:		Employer Address:				Phone:	

Primary Insurance Information

Secondary Insurance Information

Insurance Co. Name:				Insurance Co. Name:			
Insured's Name:				Insured's Name:			
Relationship to Client:				Relationship to Client:			
Policy #:		Group #:		Policy #:		Group #:	
Effective Date:		Insurance Phone #:		Effective Date:		Insurance Phone #:	

Your signature indicates that the above information is accurate and reflective of your current insurance information. You understand that you are responsible for any copayments or deductibles at each appointment. By signing below, you also understand that the benefit information that our office staff obtained is a courtesy and is NOT a guarantee that insurance will pay for the services provided. Further, you understand that you are responsible for any amount due that is not covered by your insurance provider, and you understand that the Clinic will bill you for any outstanding amounts owed. **You are responsible for reporting any insurance changes to the front desk staff at the time of your appointment.**

Name of responsible party

Signature of responsible party

Date