Office use only

Appt Date: _____

Appt Time: _____

Scheduled By: _____

Date of Referral: _____

Client Demographic Information			
Client Name:	DOB:	Age:	SSN:
[ ] Male [ ] Female	Phone Number:		
Address:			
City/State:		Zip:	
Email:			

Parent/Guardian Information (if applicable)	
Parent/Guardian Name:	(Relationship to Client):
Address (if different from above):	
Phone Number (if different from above):	

Insurance Information

Primary Insurance: [ ] Medicaid [ ] Medicare [ ] Commercial

[ ] Medicaid ID:_____ [ ] Insurance ID:_____

[ ] Commercial Ins ID:_____ [ ] Medicare ID:_____

Policy Holder: [ ]Self [ ] Other:_____

Referral Source

Name and Contact Information of Referral Source:

Services Requested

[ ] Individual Counseling [ ] Family Counseling [ ] Pre-Marital/Marital Counseling

[ ] Assessment:_____ [ ] Substance Abuse [ ] Other:_____

[ ] Medication Management-(if yes): Have you ever been seen for med. mgmt?_____

Have you recently been hospitalized? _____

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1099-A Indian Mound Dr, Mt. Sterling, KY 40353
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