Access Form-
Outpatient Therapy
Dustin Daugherty, LISW, LLC

Client's Demographic Information

Client's Name: _____ Date of Birth: _____

SS#: _____ Gender: ___Male ___Female

Physician: _____ School/Employer:_____

Home Address: _____ City:_____

State:_____ Zip Code:_____ Email: _____

Home Phone:_____ __ Cell Phone:_____

Others Living in the Home

Name of Person:_____ Relationship to client:_____ DOB:_____

Name of Person:_____ Relationship to client:_____ DOB:_____

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Name of Person:_____ Relationship to client:_____ DOB:_____

Name of Person:_____ Relationship to client:_____ DOB:_____

Name of Person:_____ Relationship to client:_____ DOB:_____

Name of Person:_____ Relationship to client:_____ DOB:_____

Emergency Contact: (someone not in your household)

Name: _____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Referral Information

Referred by: _____ Work Phone: _____

Referral Agency:_____ Agency Phone: _____

Reason for referral:

Current Medications and Diagnosis:

Insurance Information

Name of Insurance Co.:_____ Customer Service Phone:_____

Name of Subscriber (who is policy under):_____ Subscriber's DOB:_____

Subscriber's Grp Name (Employer):_____ Title XIX/Policy #:_____

Professionals/Agencies Involved

Name	Agency	Phone Numbers
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____