THE RENAISSANCE CENTRE
ADULT INTAKE INFORMATION

Note: If client is under 18, or insured on parent's plan, please complete only the back side of this form.

Client Name: _____
(Last) (First) (Middle) Name Preferred/Nick Name

Address: _____
(Street) (City) (State) (Zip)

Age: _____ Birthdate:_____ SSN:_____

Home Phone:_____ Work Phone:_____

Cell Phone: _____ Email:_____

If we need to reach you by phone, can we leave a message at: Home Work Cell (circle if "yes")

Occupation:_____ Employer:_____

Race:_____ Sex: M F □ Single □ Married □ Remarried □ Separated □ Divorced □ Widowed

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Spouse's Name:_____ Age:_____ Date of Birth_____
Address and phone number if different from above:

_____

Employer:_____

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Emergency contact (Name and Phone):_____

Referral Source: (How did you hear about us?)_____

List person(s) who can access your account information: _____

Health Insurance Company (Primary): _____

Insured's Name: _____ SSN:_____ Birthdate:_____

Health Insurance Company (Secondary, perhaps spouses coverage): _____

Insured's Name: _____ SSN:_____ Birthdate:_____

Family Physician: _____ MedicalConditions:_____

Prescription Drugs: _____

Check all that apply: Marital Problems _____ Family Problems _____ Child Problems _____ Depression _____ Physical Abuse _____
Sexual Abuse _____ Emotional Abuse _____ Substance Abuse _____ Panic/anxiety _____ Eating Disorder _____

I authorize The Renaissance Centre to release any information obtained during treatment of this individual, which is necessary to expedite and support any insurance claims on this account. I understand that I am responsible for all charges, regardless of insurance coverage. I authorize the payment of benefits otherwise payable to me, directly to this provider.

_____ _____
Client's/Guardian's Signature **Date**