Patient Information

Date_____

Client's First Name _____ Last Name _____ MI _____
Address _____ City _____ State_____ Zip _____
Telephone (Home) _____ (Work) _____
Birthdate _____/_____/_____ Age _____ Gender _____F _____M Race _____
Client's Social Security # _____
Name of Spouse/Guardian _____ Phone _____
Address _____ City _____ State _____ Zip _____
Person Responsible for Payment _____ Soc. Sec. # _____
Signature of Person Responsible for Payment X _____ (Must be signed for services to begin)

DEBIT/ CREDIT CARD INFORMATION:

I GIVE IWIN COUNSELING AUTHORIZATION TO CHARGE MY CARD FOR ANY MISSED APPOINTMENTS THE AMOUNT OF $25.00 ANY APPOINTMENT THAT IS NOT CANCELLED WITHIN 24 HOURS OF YOUR APPOINTMENT WILL BE CHARGED TO YOUR ACCOUNT.

SIGNATURE: _____

DEBIT/CREDIT CARD NUMBER: _____ EXPIRATION DATE: _____

CVV NUMBER: _____ CARD ZIP CODE: _____

EMERGENCY INFORMATION

In case of emergency, contact:
Name (1) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____
Name (2) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____
Psychiatrist _____ Phone _____
Address _____ City _____ State _____ Zip _____
Current Medications _____
Allergies _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Phone _____ Hrs _____
Spouse: Place _____ Phone _____ Hrs _____

INSURANCE INFORMATION

Primary Insurance _____
Phone_____
Contract/ID# _____
Group/Acct#_____
Subscriber_____
Subscriber Date of Birth_____
Client's relationship to Subscriber
___Self ___Spouse ___Child ___Other_____

Secondary Insurance _____
Phone_____
Contract/ID# _____
Group/Acct# _____
Subscriber _____
Subscriber Date of Birth_____
Client's relationship to Subscriber
___Self ___Spouse ___Child ____Other_____

REFERRAL SOURCE

How did you hear of our clinic (or from whom)? _____
Address _____ City _____ State _____ Zip _____
Phone _____ Relationship to referral source _____

Are you currently participating in Vocational Rehabilitation Services with the Department of Assistive and Rehabilitative Services (DARS) **YES NO**

Have you participated in Vocational Rehabilitation Services with the Department of Assistive and Rehabilitative Services (DARS) within the last 5 years? **YES NO**