Eastside Family Renewal Service

CLIENT INFORMATION FORM

(Please Print)

Today's date:	PCP:

CLIENT INFORMATION

Client's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address (w/Apt. or Suite No.):	Cell phone no.: ( )	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yahoo	❑ Google	❑ MSN	❑ Parent Map	❑ Other:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist and request a photocopy.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a client here? ❑ Yes ❑ No

Employer:	Employer address:	Employer phone no.: ( )

Is this client covered by insurance ❑ Yes (provide card) ❑ State Assistance *(Please provide coupon)* ❑ No *(if no, skip to bottom)*

Please indicate primary insurance:	Subscriber's name:

Relationship to Client	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Please indicate secondary insurance:	Subscriber's name:

Relationship to Client	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to client:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to my Clinician. I understand that I am financially responsible for any balance. I also authorize *Eastside Family Renewal Service* or insurance company to release any information required to process my claims.

Client/Guardian signature *Date*