

**PERSONAL INFORMATION**

Client's name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ SSN: \_\_\_\_\_

Name of employer: \_\_\_\_\_

Name and Phone # of responsible party if client is a minor: \_\_\_\_\_

How did you hear about us? Church?  \_\_\_\_\_ Insurance Co. referral?  Yellow page ad?   
Church Name  
Friend?  Other?  \_\_\_\_\_

Email Address: (note: it is not advisable to send confidential information with email)

**MEDICAL INFORMATION**

Doctor's name and city: \_\_\_\_\_

What medications do you currently take? \_\_\_\_\_

Whom should we contact in case of emergency? \_\_\_\_\_

**INSURANCE INFORMATION** (This information can be found on your insurance card)

Name of the primary insured person on your policy: \_\_\_\_\_

Primary insured's social security number: \_\_\_\_\_ Primary insured's birth date: \_\_\_\_\_

Primary insured's employer: \_\_\_\_\_ Policy group #: \_\_\_\_\_

Name of insurance co.: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Name of secondary insurance co.: \_\_\_\_\_

Name of insured on secondary policy: \_\_\_\_\_ Birth date: \_\_\_\_\_

Social security # of secondary insured: \_\_\_\_\_ Group #: \_\_\_\_\_

**Problem Areas**

What problems or situations have lead you to seek counseling? \_\_\_\_\_

*I acknowledge that I am responsible for all payments to Heritage Counseling Center, Inc. (HCC). I understand that It is my responsibility to bill my insurance company unless otherwise arranged with HCC, and that I am responsible for all co-payments and deductibles my insurance does not cover.*

Signature of client or responsible party \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent of Guardian if client is a minor \_\_\_\_\_ Date \_\_\_\_\_