# Caring Hearts Mental Health Services

# Client Information

**Date _____**

**Full Name _____First, Middle, Last**

**Date of Birth_____ Social Sec. #_____Gender M F Other**

**Legal Guardian's Name (If applicable) _____**

**Address_____ City_____**

**State_____ Zip Code_____**

**Home Phone_____ May we leave a message there? Y N**

**Cell Phone_____ May we leave a message there? Y N**

**Email_____ May we contact you via email? Y N**

**Secondary Email_____ May we contact you via email? Y N**

**May we send text reminders or messages? Y N**

**Occupation_____ Employer_____**

**Highest level of education completed_____ Degree Obtained_____**

**Primary Care Doctor Name_____ Phone number_____**

**Address of Primary Care Doctor_____ Date of last visit_____**

**Emergency Contact Name_____ Relation to you_____**

**I give permission to speak with _____ in an emergency at my provider's discretion**

**Emergency Contact Phone #_____**

**Spouse Full Name_____ DOB_____ Employer_____**

**You are referred by: _____ Phone #_____**

**Optional info: Ethnicity_____ Race_____**

**Religion_____ Primary Language_____**

**Therapist Name_____ Phone # _____**

**How often are your therapy appointments? _____ Release of information signed Y N**

**Cont'd**

# Insurance Information:

## Primary Insurance Carrier_____

**ID#_____ Group #_____ Name of Insurance Holder_____**

**Relation to you_____ Insurance Holder DOB_____**

**Insurance Active Date_____**

**SSN of Policy Holder_____ Address of Policy Holder_____**

**Name of Behavioral Health Insurance_____ Phone#_____**

**Do you have a Copay? $_____ Do you have a deductible? $_____**

**Have you met your deductible? Y N Don't know**

**Do you need a referral for full coverage Y N Don't know – Send Claims to_____**

**Address _____**

## Secondary Insurance Carrier _____

**ID#_____ Group #_____ Name of Insurance Holder_____**

**Relation to you_____ Insurance Holder DOB_____**

**Insurance Active Date_____**

**SSN of Policy Holder_____ Address of Policy Holder_____**

**Name of Behavioral Health Insurance_____ Phone#_____**

**Do you have a Copay? $_____ Do you have a deductible? $_____**

**Have you met your deductible? Y N Don't know**

**Do you need a referral for full coverage Y N Don't know – Send Claims to_____**

**Address _____**

**Signature_____Date_____**

**Print Name_____**