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New Client Information Sheet

Client Name: _____

Address: _____

City, State, Zip: _____

Contact Info: Home: _____ Work: _____

Cell: _____ Email: _____

Birth Date: _____ Age: _____

Employer Name: _____

Please circle your response to the following questions:

May we call you at home?	Yes	No	May we leave a message at home?	Yes	No
May we call you at work?	Yes	No	May we leave a message at work?	Yes	No
May we call you on your cell?	Yes	No	May we leave a message on cell?	Yes	No
May we contact you via email?	Yes	No	May we leave a message via email?	Yes	No

May we send information to you via email regarding upcoming activities, events, and workshops connected to Shores Counseling? Yes No

Emergency Contact: Name: _____ Phone: _____

Insurance Information

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Date of Birth: _____

Employer: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Date of Birth: _____

Employer: _____

Primary Care Physician: _____

Address: _____ Phone: _____

Medications: _____

Referred by: _____ Reason for referral: _____

Signed: _____ Date: _____