

Name of HRC Clinician _____ Date _____

HRC BEHAVIORAL HEALTH & PSYCHIATRY, PA

Client(s) Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Number _____

Email _____

Date of Birth ____/____/____ Gender: _____ Do you have a preferred pronoun? _____

If Child/Student:

Parent/Guardian's Name _____

Relationship to Child _____ Best Phone # to be reached at _____

School Currently Attending _____ Grade/Year _____

If Adult:

Name of Employer _____ Occupation _____

Spouse/Partner's Name _____

In Case of Emergency Notify:

Name _____ Relationship _____

Address _____ State/City/Zip _____

Home Phone _____ Work Phone _____ Cell Number _____

Guarantor Information (If other than self):

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Number _____

Insurance Company: _____ Policyholder _____

Policyholder SSN _____ Date of Birth ____/____/____

Employer _____

Address _____ State/City/Zip _____

Primary Care Physician: _____

Address _____ State/City/Zip _____

Phone _____ Fax _____

Referral Source: How did you find out about us? Friend Insurance EAP Employer Health Care

Professional Therapist Attorney Internet/Website Brochure Other

Information about referral: Name _____ Phone _____

Address _____ State/City/Zip _____