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_____