Crossroads Counseling Center

CLIENT INFORMATION

Provider _____

CLIENT _____ **(DOB)** _____ **Phone (H)** _____

ADDRESS _____ **Phone (W)** _____

City _____**Zip**_____ **Phone (cell)** _____

SS # _____ *** E-mail** _____

If client is a dependent/minor, please give address and phone information of parent/guardian that client lives with

Name/Address	Phone
_____	**(H)** _____
_____	**(W)** _____
_____	**(Cell)** _____
_____	**(Pager)** _____

How were you referred to me? _____

BILLING INFORMATION

PERSON RESPONSIBLE FOR PAYMENT _____ **Phone (H)** _____

RELATIONSHIP TO PATIENT _____ **Phone (W)** _____

ADDRESS _____ **Pager** _____

_____ **Phone (cell)** _____

SS # _____ **EMPLOYER** _____

WILL YOU BE USING YOUR INSURANCE? ☐ **YES** ☐ **NO**

****A COPY OF YOUR INSURANCE CARD IS REQUIRED <u>BEFORE ANY CLAIMS CAN BE FILED</u>**

FAMILY PHYSICIAN _____ **PHYSICIAN'S PHONE** _____

PREVIOUS THERAPY _____

MEDICATIONS/ALCOHOL OR DRUG USE/PHYSICAL PROBLEMS: _____

_____

PRESENTING PROBLEM: _____

_____