SOUTHCOAST
COUNSELING ASSOCIATES

Experienced Therapists offering compassionate Counseling services.

Date ____/____/____

PLEASE PROVIDE THE FOLLOWING INFORMATION:

CLIENT NAME: _____ **SSN:** _____

ADDRESS: _____
STREET APT. # CITY/TOWN STATE ZIP

HOME Phone: (_____) _____ **CELL Phone:** (_____) _____

E-MAIL Address: _____

EMPLOYED: ☐Y ☐ N **WORK Phone:** (_____) _____ **Date of Birth:** _____/_____/_____ **Age** (_____)

SEX: ☐ M ☐ F **MARITAL STATUS:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMERGENCY CONTACT: _____ (_____)_____
NAME (RELATIONSHIP) PHONE NUMBER

IS YOUR VISIT WORK RELATED? ☐Y ☐ N **ACCIDENT RELATED?** ☐Y ☐ N

PRIMARY CARE PHYSICIAN: _____ (_____)_____
NAME ADDRESS PHONE NUMBER

REFERRAL SOURCE: _____(_____)_____
NAME ADDRESS PHONE NUMBER

HEALTH INSURANCE: _____

MEMBER #: _____ **GROUP#:** _____
(IF APPLICABLE)

SUBSCRIBER: _____ _____/_____/_____
NAME DATE OF BIRTH

SUBSCRIBER ADDRESS: _____
STREET APT. # CITY/STATE ZIP

SUBSCRIBER PHONE #: (_____) _____ **SUBSCRIBER EMPLOYER:** _____

***** PLEASE COMPLETE INFORMATION BELOW ***ONLY*** IF YOU HAVE ADDITIONAL INSURANCE.

****

OTHER HEALTH INSURANCE? ☐Y ☐ N **IF SO, INSURANCE NAME:** _____

MEMBER # (for second insurance): _____

SUBSCRIBER: _____**SUBSCRIBER DATE OF BIRTH;** _____/_____/_____

SUBSCRIBER ADDRESS: _____

(PLEASE TURN PAGE OVER AND SIGN CONSENT TO TREATMENT)

****

FOR OFFIC USE ONLY.

- **INITIAL AUTH #**_____
- **DATES:** _____/_____/_____ **THROUGH:** _____/_____/_____
- **SESSIONS AUTHORIZED:** _____ **OR $$$** _____
- **CO-PAY:** _____ **DEDUCTIBLE:**_____

90791: (date) _____/_____/_____

DX(s): (_____/_____) _____

DX(s): (_____/_____) _____

DX(s): (_____/_____) _____

Next Scheduled Session ☐ **90834or** ☐ **90847:** **(date)** _____/_____/_____ **(time)** _____