CLIENT INFORMATION FORM

Patient Name:_____ Appointment Date ____/_____/_____
Last First Middle

Preferred Name:_____Birth Date:___/___/_____ Age:_____Gender (Per Insurance): ☐M ☐F

Preferred Pronoun: ☐He ☐ She ☐ They ☐ None Current Gender Identity: ☐ M ☐ F ☐ Non-Binary

Address:_____ Apt.# _____

City: _____ State:_____ Zip Code: _____

All statements and office correspondences will be sent to the above address unless otherwise indicated below.

Please check the numbers /methods of contact that you consent to leave a message:

☐Home Phone(____)____-_____ ☐Cell Phone(____)____-_____ ☐Email_____

Other Numbers ☐_____(Name) (____)____-_____ ☐ _____(Name) (____)____-_____

Patient's SS#:_____ Race:_____ Marital Status:_____

Employment Status: ☐Employed ☐Unemployed ☐Retired ☐Homemaker ☐Disabled **Student:** ☐FT ☐PT ☐Not Student

Emergency Contact Person: _____ Phone Number: (____)____-_____ Relationship_____

IF MINOR: Mother's Name_____ Father's Name_____

Name(s) of ***all Legal*** Guardian(s):_____ Phone Number: (____)____-_____

Client lives with: ☐Both parents ☐ Mother ☐ Father ☐ Other _____

PLEASE COMPLETE ALL SECTIONS

NAME OF PROVIDER YOU ARE SEEING TODAY?_____

WHO REFERRED YOU TO THE PROVIDER YOU ARE SEEING TODAY? _____

Do you want your clinician to communicate treatment information with your Primary Care Physician (PCP)?

PCP is your Internist, Pediatrician or Family Physician, not your Psychiatrist. ☐**YES** ☐**NO**

If you want information shared with other outside professionals, family or agencies please let your MD/Therapist know.
Please note, no information will be shared with any NON PRA professional, family or agency without your written consent.

Financially Responsible Party: ☐ Patient ☐ Insured Person (other than patient) ☐ Other_____

Patient's relationship to the policy holder: ☐self ☐spouse ☐child ☐other:_____

Insured Person's Information:

Insured Person/Responsible Party Name _____

☐ Address same as patient **(Where statements are mailed)**

Address:_____ Apt.# _____

City: _____ State: _____ Zip Code: _____

Home # (____)____-_____ Work #(____)____-_____ Ext. _____ **Insured Date of Birth:**___/___/_____

Insurance Company:_____ ☐HMO Site #_____ ☐ PPO ☐ POS

Insured ID#: _____ **Insured SS#:**_____

Group/Plan #: _____ **Insurance Co. Phone** #: ( )_____-_____

Employer of Policy holder: _____ Insurance Effective Date: _____/_____/_____

☐ **Self Pay** - I understand visits will not be billed through insurance by PRA.

Do you have a secondary insurance? ☐ YES ☐ NO **If YES, please give a copy to this office.**

Secondary Insurance Company Name:_____

Second Insurance ID#_____ **Second Insurance Group #**_____