AccessLiving
Counseling and Developmental Services

Client Information

First Name: | Last Name: | Middle:

Street Address: | City: | State: | Zip:

Home Phone: | Cell Phone: | Birth Date: | Sex: ☐Male ☐Female

Employer: | Occupation: | Phone:

Reason For Appointment: | Diagnosis: | Client's Spouse or Guardian:

Email: | Please check box if you would like to receive monthly billing statements via emaill: ☐

Emergency Contact: | Phone: | Relationship to Client:

Living Arrangement For Client:

Medical/Billing Information

Please give your **Medicaid/Insurance** Card to the Receptionist

Is Client Covered By: ☐Medicaid ☐Insurance ☐Other | Policy Or Medicaid #: | Group #:

Insurance Company: | Primary Subscriber Name &DOB: | Relationship to Client:

Primary Care Physician Information

Primary Physician Name: | Clinic Name:

Street Address: | City: | State: | Zip:

Phone #: | Fax #:

Pharmacy and Medication Information

Pharmacy Address: | Phone #: | Fax # :

Medication, Dosage, and Frequency:

Allergies/Special Dietary Needs: | Taking Any Type of Behavioral Medications: Yes ☐ No ☐

Miscellaneous Information

Other Therapies Received and Locations:

School Name: | Phone #: | Fax #:

Street Address: | City: | State: | Zip:

_____ _____

Client/Guardian Signature | Date