Project Point of Light

CLIENT DATA FORM

Client's Name:_____ DOB:_____
Gender: _____Male _____Female Social Security Number:_____
Address:_____
Town:_____ State:_____ Zip:_____
Primary Phone:_____ Can we leave message: _____Y _____ N
Cell Phone:_____ Can we leave message: _____Y _____ N
Marital Status: Single Married Divorced Separated Partner
Spouse's Name:_____ DOB:_____
Employer:_____ Work Phone:_____
Name of Person to Notify in Case of Emergency:_____
Relationship:_____ Phone Number:_____

PLEASE COMPLETE IF PATIENT IS A CHILD

Father's Name:_____ DOB:_____
Father's Social Security Number:_____ Phone:_____
Address:_____
Employer:_____
Mother's Name:_____ DOB:_____
Mother's Social Security Number:_____ Phone:_____
Address:_____
Employer:_____

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS

Primary Insurance/Medical Assistance Copy of Card: (Initial Here)_____
Medical Insurance Company:_____
ID Number:_____ Group Number:_____
Mental/Behavioral Health Phone Number:_____
Name of Insured Person (Primary Card Holder):_____
DOB of Insured:_____ Relationship to Patient:_____
Address of Insured:_____
Social Security Number of Insured:_____

Secondary Insurance/Medical Assistance Copy of Card: (Initial Here)_____
Medical Insurance Company:_____
ID Number:_____ Group Number:_____
Mental/Behavioral Health Phone Number:_____
Name of Insured Person (Primary Card Holder):_____
DOB of Insured:_____ Relationship to Patient:_____
Address of Insured:_____
Social Security Number of Insured:_____

I authorize Project Point of Light to release information to insurance carriers concerning my treatment. I assign the Program all payments for mental health treatment rendered to myself and my dependents. I understand I am responsible for any amount not covered by insurance.

_____ _____
Client's Signature (Parent/Guardian Signature if Child Under 14) Date

Client Name: Client ID: