FAMILY GUIDANCE CENTER OF WARREN COUNTY

INTAKE DATA FORM

NAME: ____ SOCIAL SECURITY #: _____ ____ _____

BIRTHDATE: ____________ GENDER: ______________ ETHNICITY: _____________________________

STREET ADDRESS: ________________________________ TOWNSHIP: _______________ ZIP: __________

PHONE: (Home) ___________________ (Work) ___________________ (Cell) _______________________

MARITAL STATUS: _______________________ EDUCATION COMPLETED: __________________________

VETERAN: Yes No REFERRED BY: ____

FAMILY PHYSICIAN: __________________________ TOWN: ______________ PHONE: ________________

EMERGENCY CONTACT (name, address, phone) ____

____

LIVING ARRANGEMENT: List everyone with whom you live, including self. You must provide income information only if you wish to request an "ability-to-pay" discount.

Name	Relationship	Age	Employer/Occupation	Income

TOTAL INCOME: ____________ NUMBER DEPENDENT ON INCOME: __________

INSURANCE COVERAGE: Medicaid #___________________ Medicare # ____________________

Insurance Company	Policy Number	Employer	Group#	ID#

Will any other person/agency be responsible for payment? Yes No If yes name and address of responsible party ____

I certify that the foregoing is true and accurate to the best of my knowledge. I realize that incomplete or false information may make me ineligible for an "ability-to-pay" discount and I will be responsible for paying the full fee.

Signature: ____ Date: __________________________

OFFICE USE ONLY: Case #: _________ Loc _____ Prog _____ Therapist _____________ Diag _________

Liab ___________________ % Disc ___________ $ Fee ____________ Fee Doc: ___________________