# FAMILY GUIDANCE CENTER OF WARREN COUNTY

## *INTAKE DATA FORM*

NAME: ____________________________________________ SOCIAL SECURITY #: _____ ____ _____

BIRTHDATE: ________ GENDER:___________ RACE:_________ 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 |
|---|---|---|---|---|
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TOTAL INCOME: ____________ NUMBER DEPENDENT ON INCOME: __________

**INSURANCE COVERAGE:** Medicaid #___________________ Medicare # ___________________

| Insurance Company | Policy Number | Employer | Group# | ID# |
|---|---|---|---|---|
| | | | | |
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| | | | | |

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: ___________________