Creating Connections Counseling

Intake Sheet

Patient Name:_____ Parent's Name(s):_____

Phone Numbers: Home:_____ Work:_____

Parent Cell:_____ Parent Cell:_____

Address:_____

City, State, Zip Code:_____

Emergency Contact: Name:_____ Phone:_____

Relationship to Child: Birth Parent [ ] Adoptive Parent [ ] Foster Parent [ ] Other [ ]

Patient Date of Birth: _____ Parent DOB:_____ Parent DOB:_____

Patient's School or Employer:_____

Parent's Employer:_____

Parent's Employer_____

Parent's Email:_____

Parent's Email:_____

Treatment Start Date:_____

Insurance Information

Insurance Carrier: _____ Policy #_____

Policy Holder Name: _____ Policy Holder D.O.B_____

Customer Service Phone:_____

Address:_____

By signing below I hereby give permission to my provider to bill the above insurance company for services rendered.

_____

Signature Date