

Worcester Providence Counseling Services
176 Worcester Providence Turnpike, Suite 203
Sutton, MA 01590
Phone: 508-581-8797 Fax: 508-581-8796

INTAKE INFORMATION

NAME (LAST) _____ (FIRST) _____ (MI) _____

PHONE (home) _____ (work) _____ (cell) _____

ADDRESS: _____ MAILING ADDRESS: (if different)
STREET: _____ PO BOX/STREET _____
CITY: _____ CITY: _____
STATE: _____ ZIP: _____ STATE: _____ ZIP: _____

Patient's D.O.B.: _____ Patient's Social Security #: _____ - _____ - _____

Patient's Occupation: _____

Patient's Legal Status: (circle one) Single Married Separated Divorced Widowed

FOR MINOR CHILD:

Mother's Name: _____ Father's Name _____
Phone: _____ Phone: _____
Address: _____ Address: _____
Custody Status: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

HEALTH INSURANCE:

Name of Your Insurance: _____

Insurance Address (If on back of card): _____

Name of Subscriber: _____ Subscriber's D.O.B. _____

Subscriber's Social Security _____ - _____ - _____

Relationship to Subscriber: self spouse child other _____

I hereby authorize my insurance benefits to be paid directly to _____ for the medical services rendered. I also authorize _____ to release any information necessary to process this claim.

Signature of Client

Date

Clinician

Date