CLIENT INFORMATION (Please Print)

CONFIDENTIAL

Type of Therapy: ☐Individual ☐ Couples Therapy ☐ Family Therapy

Name of Client:____ **Date of Birth:**____________ **M / F**
Last **First** Circle

Name of Client:____ Date of Birth:____________ **M / F**
Last **First** Circle

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐Widowed ☐ Engaged

Address: ____
P.O. Box or Street **City** **State** **Zip**

Preferred Phone Number:____________________________________ ☐ Cell ☐ Home ☐ Work

E-Mail Address:____

As a courtesy, Renewal Centers, Inc provides appointment reminders.
Please check your preferred method of notification. ☐ phone call ☐ email

Employed ☐ Yes ☐ No If yes, Employer's Name ________________________________

Student: ☐ Yes ☐ No If yes, Name of School: ________________________________

Family Physician and/or Other Health Care Provider: ______________________________

How were you referred to us? ____

HEALTH INSURANCE (If using)

Primary Insurance Company Name:____

Insured's ID Number ________________________________ **Group Number** ____________________

Primary Insured's name ________________________________ **Date of Birth:** ____________________

Primary Insured's Relationship to Client: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Life Partner** ☐ **Other**

Primary Insured's Gender (circle) M / F **Phone Number:** ____________________________

Primary Insured's Address (if Different from client)_____________________________________

City/State/Zip ____

Emergency Notification/Next of Kin:

Name: ______________________________________ **Relationship to Client:** ____________________

Address: ____
P.O Box or Street **City** **State** **Zip**

Phone: ______________________________ **Work/Other Phone:**_____________________________