CLIENT DEMOGRAPHIC INFORMATION FORM

Initial Appointment Date: _____ Clinician: _____

Client Name: _____ • M / F DOB: ___/___/___

Client Name: _____ • M / F DOB: ___/___/___

***Doctor's Use Only**: ICD10: _____ Copay/Charge: _____**

BROOKHAVEN CENTER FOR COUNSELING & DEVELOPMENT
2307 Cove Road
Fogelsville, PA
18051
Phone: (610)
395-3005

HOME ADDRESS_____

CITY_____STATE_____ZIP_____

*If you wish to receive mail at an address other than the home address, please provide preferred mailing address below:

_____

_____

Home phone _____-_____-_____ Messages Okay? ☐ Yes ☐ No

Work phone _____-_____-_____ Messages Okay? ☐ Yes ☐ No

Cell phone _____-_____-_____ Messages Okay? ☐ Yes ☐ No

Social Security #: _____

E-mail address *for monthly statements*:

_____

May we contact you by email? Y / N

IN CASE OF EMERGENCY, NOTIFY

NAME_____

RELATIONSHIP _____

Home phone _____-_____-_____

Work phone _____ -_____-_____EXT____

Cell phone _____-_____-_____

How did you learn about Brookhaven Center?

___ Brookhaven Website ___ Relative/ friend ___ *Physician ___ *Clergy ___ Insurance Company

___ Internet Search engine (please circle: Google, Yahoo, Bing, MSN, Other) Search words used: _____

___ Radio Advertisement ___ Yellow pages/website ___ Other _____

* If there is a referring physician or pastor, may we have your permission to thank the referral source? ☐ Yes ☐ No

Primary Insurance Information

No insurance, self-pay: _____ Primary Care Physician: _____ Phone: _____

If you have Insurance please provide the following information for the *POLICY HOLDER.*

Name of **POLICY HOLDER**: _____ Employer: _____

Insurance Company: _____ ID # (on card): _____ Group #: _____

Date of Birth of **POLICY HOLDER**: _____

Client's Relationship to **POLICY HOLDER**: ____self _____spouse ____son/daughter

Do you have secondary insurance? Y / N Date of Birth of POLICY HOLDER: _____

Name of POLICY HOLDER: _____ Employer: _____

Insurance Company: _____ ID # (on card): _____ Group #: _____

Patient's Signature and Release: I authorize Brookhaven Center to provide my insurance company with any information necessary to process my claims. I understand that my signature below is my written permission for insurance payments for services rendered to be paid directly to the provider for services. *If payment is not received within 60 days of appointment, interest will be assessed at 1% interest per month and may be subject to a $30 late payment fee per month.*

CLIENT SIGNATURE_____ DATE _____