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:
STREET: _____
CITY: _____ _____
STATE: _____ZIP:_____

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