Virginia Beach Counseling Services

# CLIENT INFORMATION SHEET

## CLIENT INFORMATION

Date: _____

Name _____ Maiden/Other Name _____
LAST FIRST MIDDLE INTIAL

Address _____
STREET APT# CITY STATE ZIP

Age_____ Date of Birth _____ [ ] Male [ ] Female Marital Status _____

Home Phone # _____ Social Security # _____

Client's Employer _____ Employer's Phone # _____

Occupation _____ Cell/ # _____

Primary Care Physician _____ Telephone # _____

Address _____
STREET CITY STATE ZIP

## SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name _____ Social Security # _____
LAST FIRST MIDDLE INITIAL

Address _____
STREET APT# CITY STATE ZIP

Home Phone # _____ Date of Birth _____

Employer _____ Employer's Phone # _____

Occupation _____ Cell/Pager # _____

## PRIMARY HEALTH INSURANCE INFORMATION

Company Name _____ Telephone # _____ Effective Date _____

Policy Holder's Name _____ Policy # _____

Policy Holder's Date of Birth _____ Social Security # _____

Client's Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other Group # _____

## SECONDARY HEALTH INSURANCE INFORMATION

Company Name _____ Telephone # _____ Effective Date _____

Policy Holder's Name _____ Policy # _____

Policy Holder's Date of Birth _____ Social Security # _____

Client's Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other Group # _____

## EMERGENCY CONTACT INFORMATION

Name of Emergency Contact _____

Telephone # /s _____ Relationship _____

Client's Name: _____ Client's Account Number: _____