Pastoral Counseling Services of the South Shore
Client Information Form

Client Name: _____ **Date:** _____

Preferred Gender Pronoun(s): _____ **DOB**: _____

Therapist Name: _____

Address Residential Street: _____

City/State: _____ **Zip Code:** _____

Mailing Address (*if different*): _____

Email Address: _____ **Okay to email?** ***Yes or No*** **(*Please Circle*)**

Phone Home: _____ **Work:** _____ **Cell:** _____

Ok to leave voicemail? **Home** ***Yes or No*** **Work** ***Yes or No*** **Cell** ***Yes or No*** (***Please Circle***)

Emergency Contact: If an emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ **Phone:** _____

Insurance Information
Name of Insured: _____ **DOB:** _____

Insurance Company: _____**ID Number:** _____

Insured's Relationship to Client: _____ **Insured's Employer:** _____

Insured Address (*if different from client's):* _____

Secondary Insurance ***(if applicable):*** _____

FOR MEDICARE ONLY-Social Security Number: _____

For Staff Use Only

Client Status *New or Returning* (Please circle) **Diagnosis (ICD-10)** _____

Is condition related to: *Employment* or *Auto Accident* or *Other Accident* (Please circle)

Insurance Authorization # _____ **Auth Start & End Dates** _____

# of authorized visits _____