

Client Information

Client Name: _____ **Date of Birth:** _____

Gender: M F Other **Marital Status:** Single Married Cohabiting Other

Employment: Full-time Student Part-time Student Employed Unemployed/Other

Address: _____
Street City State Zip

Primary Contact

Name: _____ **Relationship to Client:** Self Parent
 Stepparent Guardian Emergency Contact Other: _____

Address: Same as client _____
Street City State Zip

Preferred Phone: _____ **Preferred Email:** _____
 Mobile Work Home

No voice messages No text messages No email messages No email appt. reminders
 Voice messages OK Text messages OK Email messages OK Email appt. reminders OK

Responsible for Payment: Yes No **Monthly Newsletter:** Yes, sign me up No thanks

Secondary Contact

Name: _____ **Relationship to Client:** Parent Stepparent
 Guardian Emergency Contact Other: _____ **Responsible for Payment:** Yes No

Address: Same as client _____
Street City State Zip

Preferred Phone: _____ **Preferred Email:** _____

Emergency/Guardian/Payment Contact: Voice messages OK Text Messages OK Email messages OK

Primary Insurance

If using Blue Cross Blue Shield AZ and/or Blue affiliates, please complete the following:

Insured's Name: _____ **Date of Birth:** _____ **Gender:** M F

Relationship to Client: Self Parent Stepparent Guardian Emergency Contact Spouse
 Life Partner Other: _____ **Company/School:** _____

Address: Same as client _____
Street City State Zip

Preferred Phone: _____ **Preferred Email:** _____

Insurance/Billing Contact: Voice messages OK Text Messages OK Email messages OK

Member ID Number: _____ **Group/Enrollment Number:** _____

Plan: PPO HMO Federal Other: _____ **CoPay:** _____ **Deductible:** _____

Primary Care Physician

Name: _____ **Practice:** _____ **Phone:** _____

Yes! I want more info: Taekwondo Wellness Therapy Groups School Success Consultation

Parenting Groups Wellness Programs