intuition
wellness center
LEARN. GROW. THRIVE.

5675 N Oracle Rd, Suite 3101
Tucson, AZ 85704
Phone: 520.333.3320
www.intuitionwellness.com

CLIENT INFORMATION - ADULT

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

Preferred First Name: _____

Sex Assigned at Birth *(designated on birth certificate per healthcare insurance)*: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Cohabitating ☐ Other: _____

Employment/School Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student

Employer/School: _____

Client Address: _____
Street City State Zip

Phone: _____ **Email:** _____

Voice messages ☐ No **Email messages** ☐ No **Email appt. reminders** ☐ No

Secondary Contact

Name: _____ **Relationship to Client:** ☐ Spouse ☐ Parent

☐ Stepparent ☐ Guardian ☐ Other: _____

Address: ☐ Same as client _____
Street City State Zip

Phone: _____ **Email:** _____

Voice messages ☐ No **Email messages** ☐ No **Email appt. reminders** ☐ No

Emergency Contact

Name: _____ **Relationship to Client:** ☐ Spouse ☐ Parent

☐ Stepparent ☐ Guardian ☐ Other: _____

Address: ☐ Same as client _____
Street City State Zip

Phone: _____

Billing Information

Person(s) Responsible for Payment *(please check a minimum of one contact; self/secondary contact billing communication preferences will be noted as above)*:

☐ **Self** ☐ **Secondary Contact** ☐ **Other Contact**

Name of Other Billing Contact: _____

Relationship to Client: ☐ Spouse ☐ Parent ☐ Stepparent ☐ Guardian ☐ Other: _____

Address: ☐ Same as client _____

Street City State Zip

Phone: _____ **Email:** _____

Voice messages ☐ No ☐ **Email messages** ☐ No

Primary Insurance

Insurance: ☐ BCBSAZ ☐ Aetna ☐ Other: _____

Member ID Number: _____

Subscriber's Name: _____ **Subscriber's Date of Birth:** _____

Member Sex Assigned at Birth (designated on birth certificate per healthcare insurance)**:** ☐ M ☐ F

Secondary Insurance ☐ No **Insurance:** ☐ BCBSAZ ☐ Aetna ☐ Other: _____

Secondary Insurance ID Number: _____

Subscriber's Name: _____ **Subscriber's Date of Birth:** _____

Primary Care Physician

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

☐ **Yes! Please email Intuition Wellness Center parenting news and wellness program updates.**

"Intuition Wellness Center provides integrated clinical services and wellness programs to clients without discrimination on the basis of gender identity and expression, sex, sexual orientation, race, color, national or ethnic origin, citizenship, marital status, religious beliefs, age, ability, appearance or any other characteristic protected under applicable federal or state law."

Additional Information - Optional

While you are not required to answer the following questions, knowing more about the different facets of your identity helps Intuition Wellness Center team members provide support through services that are truly tailored and inclusive. You may prefer to provide additional information privately during your appointment.

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/FTM ☐ Transgender Female/MTF

☐ Non-Binary ☐ Genderqueer ☐ Unknown ☐ Choose not to disclose ☐ Other: _____

Sexual Orientation: ☐ Lesbian/Gay/Homosexual ☐ Straight/Heterosexual ☐ Bisexual ☐ Unknown

☐ Choose not to disclose ☐ Other: _____

Pronoun: ☐ they/them ☐ he/him ☐ she/her ☐ Other: _____

Race: Please check all that apply

☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific

☐ Asian ☐ Hispanic/Latino-a ☐ White/Caucasian ☐ Other: _____

Ethnic Identity: _____

Primary Language Spoken at Home: _____