

**Full Circle Counseling
Usha Davis, LCSW
INTAKE INFORMATION**

(To be completed by client)

IDENTIFYING INFORMATION

Today's Date _____

Legal Name: _____

Preferred Name: _____

Date of Birth: _____

Age: _____

Partner's Name (if being seen as a couple): _____

Address: _____

City, State, Zip: _____

Home phone: _____

Cell phone: _____

Social Security (ID) Number: Self: _____

Gender as Specified on Insurance: Male

Female **Gender Self-Identification, if different:** Male Female Other

INSURANCE INFORMATION

Insurance Company: _____ **Phone:** _____

Insurance Company Address: _____ **City, State, Zip:** _____

Insurance Identification Number: _____ **Group Number:** _____

Secondary insurance: _____ **Phone:** _____

Secondary Company Address: _____ **City, State, Zip:** _____

Secondary Identification Number: _____ **Group Number:** _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

Signature Date

FOR PROVIDER USE ONLY

DSM-5: DIAGNOSIS:

ICD-10 DIAGNOSIS: