Hollie French
Art Therapy & Counseling, LLC

Child/Adolescent Contact Information

Client Name: _____Date: _____
Legal Name (if different):_____
Address: _____Date of Birth: _____
City: _____State: _____ Zip: _____Gender: _____ Age: _____

Insurance Information

Primary Health Insurance:_____ Subscriber Name:____
Relationship to Subscriber: _____Subscriber Date of Birth:
ID number: _____Group/Policy #: _____

Additional Health Insurance:_____ Subscriber Name:____
Relationship to Subscriber: _____Subscriber Date of Birth:
ID number: _____Group/Policy #: _____
Type of Additional Coverage: Secondary EAP (Employee Assistance Program)

Financial Guarantor (Financially Responsible Person) Information

Name: _____Relationship:_____
Address: _____Date of Birth: _____
City: _____State: _____ Zip: _____

Contact Information

Please complete information and check boxes below where relevant or available

Legal Guardian?	**Phone /Text Messages OK?** Yes	No
☐ Mother's Name _____	☐	☐
Home Phone ( )_____	☐	☐
Work Phone ( ) _____	☐	☐
Cell Phone ( ) _____		
☐ Father's Name _____	☐	☐
Home Phone ( )_____	☐	☐
Work Phone ( )_____	☐	☐
Cell Phone ( )_____		
☐ Step-Mother's Name _____	☐	☐
Contact # ( ) _____		
☐ Step-Father's Name _____	☐	☐
Contact # ( ) _____		
Contact # ( ) _____		
☐ Non-parent Legal Guardian's Name _____	☐	☐
Relationship to youth _____		
Contact # ( ) _____	☐	☐
☐ Youth (client)_____		
Contact # ( ) _____		

Emergency Contact Information (other than the people noted above)

Name_____Home Phone ( ) _____
Work Phone ( )_____Cell Phone ( ) _____
Relationship to child: _____

Primary Care Physician Information

Current Physician_____
Physician Address_____
Physician Phone ( )_____Physician Fax ( ) _____

School Information

Current School_____Primary teacher's name _____
Main contact at school _____School phone number ( ) _____