Hollie French
Art Therapy & Counseling, LLC

Adult Contact Information

Name: _____ Date: _____
Legal Name (if different):_____
Address: _____ Gender: _____
City: _____State: _____ Zip: _____Date of Birth: _____

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)

Contact Telephone Numbers

Please complete relevant information and indicate the number at which you wish to be contacted first.

		Text/ Phone Messages OK? Yes	No	Primary contact number?
HOME:	( ) _____	☐	☐	
WORK:	( ) _____	☐	☐	
CELL:	( ) _____	☐	☐	

Marital Status

☐ Single ☐ Divorced (_____years) ☐ Living as Married (_____years)
☐ Married (____years) ☐ Separated (_____years) ☐ Widowed (_____years)

Spouse's/Partner's Name:_____
If I am unable to reach you, is it OK to contact your spouse/partner? ☐ Yes ☐ No
If yes, spouse/partner's phone number: ( ) _____

Employment Status:

Are you employed? ☐ Yes ☐ No Are you using EAP? ☐ Yes ☐ No

Employer Name:_____

Emergency Contact Information

Name:_____
Address: _____
Phone: ( )_____ Relationship to you: _____

Primary Care Physician

Current Physician:_____
Physician Address:_____
Physician Phone Number: ( )_____
Physician Fax Number: ( ) _____

Referent

By whom were you referred? _____