BOYS TOWN

Behavioral Health Clinic
Client Information Sheet

Client Information

Last Name:	First:	MI:	Birth Date:
Address:	City:	State:	Zip:
Home Phone:	Work Phone:		
Marital Status: M D S W	Gender: ☐ M ☐ F	Is Client Currently a Student? ☐ Yes ☐ No	
Primary Care Physician:	Referring Physician:		

Person to Notify in Case of Emergency (friend or relative not living with you):

Name _____ *Relationship* _____ *Phone* _____

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to Answer

Ethnicity: ☐ Hispanic/Latino Origin ☐ Not Hispanic/Latino Origin ☐ Decline to Answer ☐ Unknown

Responsible Party (Legal Guardian)				Spouse/Other Parent			
Last Name:	First:	M.I.:	Birth Date:	Last Name:	First:	M.I.:	Birth Date:
Address:				Address:			
City:	State:	Zip:		City:	State:	Zip:	
Home Phone:	Work Phone:	Cell Phone:		Home Phone:	Work Phone:	Cell Phone:	
E-mail Address:	Relationship to Client:			E-mail Address:	Relationship to Client:		
Circle One: Employed Unemployed Disabled Retired				Circle One: Employed Unemployed Disabled Retired			
Employer Name:				Employer Name:			
Employer Address:	Phone:			Employer Address:	Phone:		

Primary Insurance Information		Secondary Insurance Information	
Insurance Co. Name:		Insurance Co. Name:	
Insured's Name:		Insured's Name:	
Relationship to Client:		Relationship to Client:	
Policy #:	Group #:	Policy #:	Group #:
Effective Date:	Insurance Phone #:	Effective Date:	Insurance Phone #:

Your signature indicates that the above information is accurate and reflective of your current insurance information. You understand that you are responsible for any copayments or deductibles at each appointment. By signing below, you also understand that the benefit information that our office staff obtained is a courtesy and is NOT a guarantee that insurance will pay for the services provided. Further, you understand that you are responsible for any amount due that is not covered by your insurance provider, and you understand that the Clinic will bill you for any outstanding amounts owed. **You are responsible for reporting any insurance changes to the front desk staff at the time of your appointment.**

Name of responsible party _____ Signature of responsible party _____ Date _____