Renewed & Restored
PERSPECTIVES

CLIENT INFORMATION FORM

Consumer Name: _____ Date of Admission: _____

Insurance/Medicaid ID# (please provide a copy of your insurance card): _____
D.O.B.: _____ SS #: _____

Known Allergies: _____

Address: _____
Street City State ZIP Code County

Telephone: _____ Email: _____ Gender: _____

Marital Status (**S**ingle, **M**arried, **W**idowed): _____ Ethnicity: _____

Occupation/School and Amount of hours worked/attended weekly: _____

List of CURRENT Medication(s) along with dosage (if known)**:**

_____ _____ _____

_____ _____ _____

Legally Responsible Adult (if individual above is under the age of 18 and address is different)**:**

Name of Parent/Legal Guardian: _____

Address: _____
Street City State ZIP Code County

Occupation and Amount of hours worked weekly: _____

Please list two (2) Emergency Contact's Information:

1. _____ _____
Name Phone Number

Address:

_____
Street City State ZIP Code County

2. _____ _____
Name Phone Number

Address:

_____
Street City State ZIP Code County

Renewed & Restored
PERSPECTIVES

CLIENT INFORMATION FORM

Others in the Home (Please list names of individuals and relationship to individual seeking services):

_____

_____

Reason for Referral:

_____

_____

_____

_____

_____

CURRENT Preferred Physician and Other Specialist (dentist, chiropractor, etc.) (In case of emergency, R&R will help you obtain one if you do not currently have a Primary Care Physician):

1. _____ _____
Name Phone Number

Address: _____
Street City State ZIP Code County

2. _____ _____
Name Phone Number

Address: _____
Street City State ZIP Code County

Renewed & Restored
PERSPECTIVES

CLIENT INFORMATION FORM

Hospital Preference:

1. _____ _____
Name Phone Number

Address: _____
Street City State ZIP Code County

My signature below states that I have provided accurate information on this form and that I was given an opportunity to ask questions.

Consumer's Signature (Parent/Guardian) and Date: _____

Date of Discharge: _____