Connecticut Behavioral Health Associates, P. C.

CLIENT INTAKE FORM

Client Name: ________________________________ Date of Birth: ______________ Date: ___________

Age: _________ Social Security #: ________ - ________ - ________ ☐ Male ☐ Female

Street Address: ____ City: __________________________

State: _____________ Zip Code: _____________ Home Phone: ______________________________

Cell Phone: _________________________ Email ____

Office Locations: ☐ New London ☐ Norwich ☐ Pawcatuck ☐ Groton ☐ Plainfield
☐ Old Saybrook ☐ New Britain ☐ Southington ☐ Hamden ☐ Glastonbury

Seeking: ☐ MEDICATION EVALUATION ☐ THERAPY-INDIVIDUAL/FAMILY ☐ DRUG/ALCOHOL TREATMENT

Reason or Symptoms: ____

____

Current Medications & Prescribing Doctor: ____

____

PRIMARY INSURANCE INFORMATION

Subscriber's Name: ____

Subscriber's DOB: ______________________ Subscriber's SSN #: _______________________________
Client's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company Name: ________________________________ Effective Date: ___________________

Insurance ID#: _________________ Group #: ___________ Insurance Company Phone: _______________

SECONDARY INSURANCE INFORMATION

Subscriber's Name: ____

Subscriber's DOB: ______________________ Subscriber's SSN #: _______________________________
Client's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company Name: ________________________________ Effective Date: ___________________

Insurance ID#: _________________ Group #: ___________ Insurance Company Phone: _______________

OFFICE TO COMPLETE

Referred to: _______________________ **Appointment Date & Time:** ___________________________

Additional Comments: ____

____

____