Demographic Form
CHAUTAUQUA HEALTHCARE SERVICES & BEACHSIDE COUNSELING

CLIENT IDENTIFYING INFORMATION ***You MUST fill out this form completely.***

Last Name	First Name	Middle	Suffix
Alias(es) / Maiden Name	Last	First	Middle
Gender	Male Female	Currently Pregnant YES NO	
Children 1 and under currently living in the household YES NO		Currently use tobacco products YES NO	
Mailing Address			
City		State	Zip
County		OK to send mail?	*YES NO*
Cell Phone	( )	OK to call cell?	*YES NO*
Home Phone	( )	OK to call home?	*YES NO*
Work Phone	( ) Ext	OK to call work?	*YES NO*
Email Address		OK to send email?	*YES NO*
SS #	Date of Birth		

Ethnicity	*Mexican-American Mexican Other Hispanic None of the Above*	Race	*White Black Asian Multi-Racial Other:*
Marital Status	*Married Divorced Separated Never Widowed Other:*	Employment Status	*Employed Unemployed Retired Student Other:*
Residential Status *(Who do you live with?)*			
Highest Education/Grade completed		Primary Language	
Are you a veteran of the U.S. Armed Services?	*YES NO*		

Primary Care Physician			
List of Allergies (drug, food, other)			
Reason for Seeking Services			
Referred by		Probation Officer	
Court Ordered	*YES NO*	Probation Phone	

EMERGENCY NOTIFICATION INFORMATION

Emergency Contact Name				Phone	
Address		Relationship to the Client:			
City		State		Zip	

LEGAL INFORMATION

Legal Status of Client	*Adult Minor with Guardian Adult with Guardian Advocate Other:*				
If the client is a minor, please fill out the following information:					
Responsible Person		Relationship			
Address		Phone			
City		State		Zip	
Resp Person Employment Phone		Employment Place			

Are you feeling homicidal or suicidal? *YES NO* **(if YES, please see Front Desk staff immediately)**

Client Signature _____ **Date** _____

FOR OFFICE USE ONLY **Client ID #** _____

Staff Signature _____ **Review Date** _____

Form # 1004-A (Dev 4/00 ; Rev 11/00, 05/03, 04/05, 04/08, 07/09, 10/10, 05/13, 12/13, 06/14, 07/15, 01/16)

Client Financial Review Form
Chautauqua Healthcare Services & Beachside Counseling

Client Name		Case Number	

Alternate Billing Address (if applicable)

Name					
Street					
City		State		Zip	

Place Employed			
Family Size (including self)		Number of Dependents under 18	

Income	Monthly	Income	Monthly
Employment:		VA	
Pension		Other	
Spouse		SSI	
Family		SSDI	

You MUST bring in proof of household income in order to apply for a discount.

Physical Street Address (if different from mailing address)

Street					
City		State		Zip	

Insurance Information

Insurance Name			Group Name		
Policy Number			Group Number		
Policy Holder Information					
Name (Last, First, MI)					
Relationship to Insured		DOB		Sex	

Do you have a secondary insurance policy? YES NO

Client Signature _____ **Date** _____

FOR OFFICE USE ONLY

☐ Income Verified?	Reason Not Verified	
☐ Slide?	Slide%	
☐ Has No Insurance?	Comments:	
☐ Assignment of Benefits?		

Staff Signature _____ Date _____