



Client Information

Date: _____

Name: _____ SS#: _____ Sex: ___ Date of Birth: _____

Relationship to Insured: _____ (if payment source is insurance)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

(Please check each box if permitted to leave a message on that phone number)

Email: _____

Address: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

Name: _____ SS#: _____ Sex: ___ Date of Birth: _____

Relationship to Insured: _____ (if payment source is insurance)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

(Please check each box if permitted to leave a message on that phone number)

Email: _____

Address: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

Children (if part of treatment):

Name: _____ SS#: _____ Sex: ___ Date of Birth: _____

Name: _____ SS#: _____ Sex: ___ Date of Birth: _____

Other household members and their ages: _____

Emergency Contact: _____ Phone: _____

Physician: _____ Phone: _____

Insurance Information: (Both sides of your insurance card and drivers license needs to be copied by the Front Desk)

Name of the Insured: _____ DOB _____ Provider: _____

Policy/Group #: _____ ID: _____

I authorize the release of information to WBC in order for WBC to send in a claim, and my insurance carrier to pay benefits associated with my care directly to Well Baby Center.

Signature: _____ Date: _____ Signature: _____ Date: _____

Office Use Only

CLINICIAN: _____ DATE: _____ FEE: _____

Date of Intake: _____

Intake Completed by: _____

Clinician Assigned: _____

Days client is available: _____