Christian Family Care

3603 N. 7th Avenue ~ Phoenix, AZ 85013 602-234-1935 6063 E. Grant Road ~ Tucson, AZ 85712 520-296-8255

Counseling Family Information

Identified Client's Name: _____SS#_____Under 18 Yrs? No❒ Yes❒

Emergency contact – (REQUIRED FOR ALL CLIENTS)

Name: _____ Relationship: _____Phone: _____

Responsible Party (If client is a minor, name of parents or legal guardian, or person who has custody of client: _____)

Full Legal Name: _____ Marital Status: _____
First Middle Last

Address: _____City: _____ Zip: _____

Email Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Employer/Occupation: _____ Work Phone Number: _____

Social Security Number:_____ Birth date: _____Age: _____State of Birth: _____

Last School Attended:_____ Last Grade Completed: _____

Race/Ethnicity: (Check All That Apply) ❒White ❒ Black ❒American Indian ❒ Pacific Islander ❒ Asian ❒ Hispanic ❒ Other? _____ __

Present Marriage Date: _____ Previous Marriage Dates: _____Termination Dates: _____

Religious Preference: ❒ Undeclared ❒ Catholic ❒ Protestant ❒ Jewish ❒ Islamic ❒ Other? _____

Church Name:_____ Pastor: _____

Spouse

Full Legal Name: _____ Marital Status: _____
First Middle Last

Address: _____City: _____ Zip: _____

Email Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Employer/Occupation: _____ Work Phone Number: _____

Social Security Number:_____ Birth date: _____Age: _____Place of Birth: _____

Last School Attended:_____ Last Grade Completed: _____

Race/Ethnicity: (Check All That Apply) ❒White ❒ Black ❒American Indian ❒ Pacific Islander ❒ Asian ❒ Hispanic ❒ Other? _____ __

Present Marriage Date: _____ Previous Marriage Dates: _____Termination Dates: _____

Religious Preference: ❒ Undeclared ❒ Catholic ❒ Protestant ❒ Jewish ❒ Islamic ❒ Other? _____

Church Name:_____ Pastor: _____

Children *(If one of the children is the client please list them here also.)*

Name	Race/Ethnicity	Birth date	Age	Sex	Name	Race/Ethnicity	Birth date	Age	Sex

If client is a minor: Name of School:_____ Who has authorization to pick up this child? _____

Additional Information

Attending Physician:_____Phone: _____

Have you received other services from CFCA? ❒ Yes ❒ No If Yes, please describe: _____

Are you currently working with another agency or therapist? ❒ Yes ❒ No If Yes, Please describe: _____

Gross Annual Income: _____ Referred By: _____

Do You Have Insurance? ❒ Yes ❒ No Insurance Provider: _____

**Please allow our staff to copy the front and back of your insurance card, and provide any additional information needed if we will be filing your claims. You can also use our receipts to file your own claim with your health insurance company.*

Authorization and Assignment of Benefits: I authorize Christian Family Care to bill our insurance provider for services provided. I further authorize payment of medical benefits directly to Christian Family Care.

Insured's Signature: _____ Date: _____