Christian Family Care

Central Arizona	3603 N. 7th Avenue, Phoenix, AZ 85013	602.234.1935
Southern Arizona	6063 E. Grant Road, Tucson, AZ 85712	520.296.8255
Northern Arizona	7515 E. Long Look Drive, Prescott Valley, AZ 86314	928.443.1150

CLIENT INFORMATION

First Name:	**Last Name**:	Middle Name:	Nickname (if applicable):
Date of Birth:	Age:	Gender:	
If client is a minor, **Name of Parent/Legal Guardian/Person** whom has **custody of client**:		Relationship to minor:	
Client referred by (type of referral):	Name of Organization or Person providing referral:		
Language Preference: ☐-English ☐-Other (list):			
Employer (if applicable):	Occupation (if applicable):		
To better understand and serve the community's needs, CFC does participate in requesting the client demographic information below. Although very helpful, your participation is not required and this demographic information is only used for informational purposes: Race/Ethnicity (check all that apply): ☐-White ☐-Black ☐-American Indian ☐-Pacific Islander ☐-Asian ☐-Hispanic ☐-Other (list):			
Religious Preference: ☐-Undeclared ☐-Catholic ☐-Protestant ☐-Jewish ☐-Islamic ☐-Other (list):			

CONTACT INFORMATION

Address 1:		City:	State:	Zip Code:	County:
Address 2:		City:	State:	Zip Code:	County:
Email:	Cell Phone:	Work Phone:		Home Phone:	
Name of Emergency Contact (**if client is a child** please **list parent/guardian**):		Emergency Contact Phone Number:			
Employer of Emergency Contact:		Occupation of Emergency Contact:			

HOUSEHOLD INFORMATION

Household Income:	If an Adult Client, Marital Status:	Family Size:

OTHER CHILDREN IN HOUSEHOLD

(Not including client)

Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

Does the client have insurance?: ☐Yes ☐No	Insurance Provider:
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: ☐Yes ☐No	
Insured's Signature:	**Date:**