Alliance Counseling and Education Center

Client Demographic Form

Please fill this form out completely. You are responsible for providing updates if any information changes.

Today's Date: ________________ Therapist: __________________

CLIENT INFORMATION (Child/Adolescent Information)

Full Name: ____ Grade Level: _______________________________

Does your child prefer to by another name: ? ☐ Yes ☐ No If yes, please list: _________________________

Date of Birth: ________________________ Age: _________ Sex: ☐ Male ☐ Female

Street Address: __________________________________ City: ____________ State: _________ Zip: ________

Social Security Number: ____________________________ Driver's License Number: _______________________

School Name: ___________________________________ Home Phone Number: _________________________

Cell Phone Number: ________________________________ Referred to Provider by: _________________________

LEGAL INVOLVEMENT

If you are currently involved in a child custody dispute, please complete the following.

Your Attorney's Name: ________________________________ Legal Assistant: ____________________________

Address: ____
Street City State Zip Code

Telephone Number: ____________________________________ Fax Number: ____________________________________

Is there an Ad Litem or Ambicus Attorney assigned? ☐ Yes ☐ No If yes, who? ________________________

Address: ____
Street City State Zip Code

Telephone Number: ____________________________________ Fax Number: ____________________________________

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Client Demographic Form Continued

PARENT/GUARDIAN CONTACT INFORMATION

Mother's Name: ______________________________ Mother's Date of Birth: ____________________

Street Address: ______________________________ Social Security Number: ____________________

City/State/Zip: ______________________________ Home Phone No: ____________________

Employer: ______________________________ Cell/Work No: ____________________

Father's Name: ______________________________ Father's Date of Birth: ____________________

Street Address: ______________________________ Social Security Number: ____________________

City/State/Zip: ______________________________ Home Phone No: ____________________

Employer: ______________________________ Cell/Work No: ____________________

CONTACT AUTHORIZATION

What number can we leave a message on? Home ☐ Cell ☐ Other ☐ ____________________

Can we email you? (Appointment Reminders, Counseling information, etc.)? Yes ☐ No ☐

If yes, what email address would you like to receive messages: ______________________________

By providing the information listed above, I authorize ACEC to contact me through the approved methods listed above. I reserve the right to revoke this consent by providing ACEC written notice.

Signature: ______________________________ Date: ______________________________

SERVICE YOU ARE SEEKING

☐ Individual Counseling ☐ Couples Counseling ☐ Family Counseling

GUARANTOR'S INFORMATION

Guarantor's Name: _________________________ Date of Birth: ___________________ Sex: ________

SSN#: _____________________________________ Address: _______________________________________

Home Phone: ______________________________ City: ___________ State: _______ Zip: ________

Cell Phone: ________________________________ Relationship to Patient: __________________________

Guarantor's Employer: ______________________ Employer's address: ______________________________

Employer's Phone: _________________________ City: ___________ State: ________ Zip: ________

PRIMARY INSURANCE

Insurance Name: ___________________________ Behavioral Health Phone #: ________________________

Address: __________________________________ City: ___________ State: _________ Zip: ________

Policy #: __________________________________ Group #: ____

Effective Date: ____________________________

Please complete if subscriber's information is different from the guarantor's information:

Subscriber's Name: ________________________ SSN#: ___________________ Date of Birth: ________

Address: __________________________________ City: ___________ State: _________ Zip: ________

Home Phone: ______________________________ Cell Phone: ______________________________________

Relationship to patient: ____

SECONDARY INSURANCE

Insurance Name: ___________________________ Behavioral Health Phone #: ________________________

Address: __________________________________ City: ___________ State: _________ Zip: ________

Policy #: __________________________________ Group #: ____

Effective Date: ____________________________

Please complete if subscriber's information is different from the guarantor's information:

Subscriber's Name: ________________________ SSN#: ___________________ Date of Birth: ________

Address: __________________________________ City: ___________ State: _________ Zip: ________

Home Phone: ______________________________ Cell Phone: ______________________________________

Relationship to patient: ____

IN CASE OF EMERGENCY

Whom may we contact in the event of an emergency? (Please list a local family member or friend not living at the same address).

NAME	RELATIONSHIP	HOME PHONE	WORK/CELL PHONE

PLEASE READ THE INFORMATION BELOW THOUROUGHLY

I consent to ACEC beginning treatment. I understand that to meet my counseling goals it is best to follow therapeutic suggestions. I also understand that I have the right to discontinue counseling or refuse treatment at any time. I understand that I am responsible for any balance due prior to my decision to discontinue treatment.

______________________________________ ______________________________
Client/Guardian Signature Date