CORNERSTONE HEALTH

Medical ▪ Counseling ▪ Recovery

Client Demographic Sheet (Adult)

General Information (Client) Date: _____

First Name: _____ M.I.: _____ Last Name: _____ DOB: _____Age: _____

Gender: _____ Social Security Number: _____

Mailing Address: _____ City: _____ State: _____Zip: _____

Home Address: _____City: _____ State: _____Zip: _____

Email address: _____

Employed: ☐ No ☐ Full time ☐ Part time ☐ Self ☐ Student Occupation: _____

Please let us know how we may contact you:

Home Phone: _____Cell Phone: _____Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

How did you hear about us? _____

Insurance Information: PRIMARY: _____ ☐ I do not wish for my insurance to be billed.

Policy Holder Information: Please provide a copy of the front and back of your insurance card.

Last Name: _____ First Name: _____ M.I.: _____DOB: _____

Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Insurance Information: SECONDARY: _____ ☐ I do not wish for my insurance to be billed.

Policy Holder Information: Please provide a copy of the front and back of your insurance card.

Last Name: _____First Name: _____ M.I.: _____ DOB: _____

Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

_____ _____

Signature of Client or Authorized Representative Date