SOUTHWEST FAMILY
GUIDANCE CENTER & INSTITUTE

NAME: _____

DOB: _____ **ID #:** _____

General Intake Form

DATE: _____ **SEX:** ☐ FEMALE ☐ MALE **RACE/ETHNICITY:** _____

PRIMARY LANGUAGE: _____ **SS NUMBER:** _____

CHECK ALL THAT APPLY: ☐ CHILD ☐ NEVER MARRIED ☐ MARRIED ☐ DIVORCED ☐ STUDENT ☐ EMPLOYED

SCHOOL: _____ **EMPLOYER:** _____

RESIDENTIAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MAILING ADDRESS *(IF DIFFERENT)*: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE 1: _____ **PHONE 2:** _____

IF UNDER 18: GUARDIAN NAME/RELATION: _____

EMERGENCY CONTACT NAME/RELATION: _____

EMERGENCY CONTACT PHONE: _____

PSYCHIATRIST: _____ **PHONE:** _____

PRIMARY CARE PHYSICIAN: _____ **PHONE :** _____

PAYMENT TYPE: CHECK BOX AND COMPLETE REQUIRED INFORMATION

☐ **COMMERCIAL INSURANCE**	COMPANY NAME	POLICY NUMBER	CO-PAY AMOUNT
☐ **MEDICAID**	MEDICAID TYPE	MEDICAID ID # (BLUE CARD)	CENTENNIAL HEALTHCARE ID NUMBER
☐ **PRIVATE PAY**	**CASH, CHECK AND CREDIT CARDS** (VISA, MASTERCARD & DISCOVER), ALBUQUERQUE OFFICE ONLY **RATES:** $65 INITIAL VISIT (INTAKE) / $55 REGULAR VISIT / PRICES FOR SPECIAL SERVICE VARY		
☐ **OTHER** (PLEASE EXPLAIN)			

PRIMARY INSURED'S INFORMATION (IF DIFFERENT THAN ABOVE):

NAME: _____ **DOB:**

SS#: _____ **SEX:** ☐ FEMALE ☐ MALE

INSURED'S EMPLOYER OR SCHOOL: _____

RELATION TO CLIENT: ☐ SPOUSE ☐ CHILD OTHER: