**Client Information Sheet**

**Name of Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX DOB**

***(Nombre)* Last *(Apellido)* First (*Primero) (Sexo) (Fecha de Naciemiento)***

**Address**

***(Dirrecion)* Street Address *(Calle)*  City *(Cuidad)*  State *(Estado)*  Zip *(Codigo Postal)***

**Name of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(*Nombre del Padre/Guardian) (Correo Electronico)***

**Telephone: Home Cell Work**

***(teléfono) (Cellular) (Trabajo)***

**Client’s Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT INFORMATION (Informaci)**

**Name Relationship to Client Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell#**

**DOCTOR OR OTHER HEALTH CARE PROVIDER**

􀀀 **Georgia Medicaid** 􀀀 **WellCare of Georgia** 􀀀 **Amerigroup Community Care**

􀀀 **PeachState** **Health Plan** 􀀀 **No Insurance** 􀀀 **Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance #:**

**Telephone Number of Doctor or Other Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RACE**

􀀀 **Black (Black Non-Hispanic/Latino)** 􀀀 **White (White Non-Hispanic/Latino)** 􀀀 **Asian** 􀀀 **Mixed Race**

􀀀 **Black Hispanic/Latino** 􀀀 **White Hispanic/Latino** 􀀀 **Amer. Indian/Alaskan Native** 􀀀 **Unknown**

**PREFERRED LANGUAGE** 􀀀 **English** 􀀀 **Spanish** 􀀀 **Other(specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REFERRAL SOURCE**

**Name: Relationship to Client:**

**Contact Number: Email Address:**

Revised 08/19/19