

PHOCIS Client Information Worksheet

CLIENT #1 DEMOGRAPHICS

Legal Name: (Last, First, Middle):		Suffix (Jr., Sr., III):	Mother's Maiden Name:
Date of Birth (MM/DD/YYYY):	Social Security Number (SSN):	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other	
Birth Country:	Birth State:	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign <input type="checkbox"/> Other: _____	Foster Child: <input type="checkbox"/> Yes <input type="checkbox"/> No
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/ Pacific Island <input type="checkbox"/> White <input type="checkbox"/> Other: _____	Hispanic or Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Unknown	Insurance Type: <i>(Please show proof of insurance)</i> <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private (Payer ID/EDI: _____) <input type="checkbox"/> No Insurance Member ID: _____ Group ID (if applicable): _____ Policyholder Name: _____ Client Relation to Policyholder: _____

ADDRESS (PLEASE LIST ALL THAT APPLY)

Street Number and Name	City	State	Zip Code	May we contact you?
Mailing:				<input type="checkbox"/> Yes <input type="checkbox"/> No*
Confidential:				<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical:				<input type="checkbox"/> Yes <input type="checkbox"/> No

*A confidential address **MUST** be provided if checked.

PHONE NUMBERS (LIST ONLY NUMBERS AT WHICH WE MAY CONTACT YOU)

Phone Number:	Message/Text Phone Number:
Emergency Contact Name:	Emergency Contact Phone Number:

HOUSEHOLD INCOME

Income: \$ _____ per <input type="checkbox"/> Year <input type="checkbox"/> Month <input type="checkbox"/> Twice a Month <input type="checkbox"/> Every Other Week <input type="checkbox"/> Week <input type="checkbox"/> Hour (Numbers of hours worked per week: _____)	Number of people in household supported by income:
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GUARDIANSHIP (REQUIRED FOR ALL CLIENTS UNDER 18 YEARS OF AGE)

Name: (Last, First, Middle)
Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____

PLEASE SIGN AND DATE TO VERIFY INFORMATION IS CORRECT

Signature:	Today's Date:
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CLIENT #2 DEMOGRAPHICS – Contact Information and Income are the Same as Client #1				
Legal Name: (Last, First, Middle):		Suffix (Jr., Sr., III):		Mother's Maiden Name:
Date of Birth (MM/DD/YYYY):		Social Security Number (SSN):		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
Birth Country:	Birth State:	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign <input type="checkbox"/> Other: _____		Foster Child: <input type="checkbox"/> Yes <input type="checkbox"/> No
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/ Pacific Island <input type="checkbox"/> White <input type="checkbox"/> Other: _____		Hispanic or Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Unknown	Insurance Type: (Please show proof of insurance) <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> Private (Payer ID/EDI: _____) Member ID: _____ Group ID (if applicable): _____ Policyholder Name: _____ Client Relation to Policyholder: _____
Guardian Name (Last, First, Middle):		Guardian Relationship to Client: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____		
CLIENT #3 DEMOGRAPHICS – Contact Information and Income are the Same as Client #1				
Legal Name: (Last, First, Middle):		Suffix (Jr., Sr., III):		Mother's Maiden Name:
Date of Birth (MM/DD/YYYY):		Social Security Number (SSN):		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
Birth Country:	Birth State:	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign <input type="checkbox"/> Other: _____		Foster Child: <input type="checkbox"/> Yes <input type="checkbox"/> No
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/ Pacific Island <input type="checkbox"/> White <input type="checkbox"/> Other: _____		Hispanic or Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Unknown	Insurance Type: (Please show proof of insurance) <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> Private (Payer ID/EDI: _____) Member ID: _____ Group ID (if applicable): _____ Policyholder Name: _____ Client Relation to Policyholder: _____
Guardian Name (Last, First, Middle):		Guardian Relationship to Client: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____		
CLIENT #4 DEMOGRAPHICS – Contact Information and Income are the Same as Client #1				
Legal Name: (Last, First, Middle):		Suffix (Jr., Sr., III):		Mother's Maiden Name:
Date of Birth (MM/DD/YYYY):		Social Security Number (SSN):		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
Birth Country:	Birth State:	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> American Sign <input type="checkbox"/> Other: _____		Foster Child: <input type="checkbox"/> Yes <input type="checkbox"/> No
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/ Pacific Island <input type="checkbox"/> White <input type="checkbox"/> Other: _____		Hispanic or Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Unknown	Insurance Type: (Please show proof of insurance) <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> Private (Payer ID/EDI: _____) Member ID: _____ Group ID (if applicable): _____ Policyholder Name: _____ Client Relation to Policyholder: _____
Guardian Name (Last, First, Middle):		Guardian Relationship to Client: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____		