advanced direction
530 Rockland Road, Suite 100
Crystal Lake, IL 60014
815-345-3072

Screening Information

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY** Readmit: ___ Yes ___ No
Date_____ Client's Social Security # _____ Case # _____
Client's First Name _____ Last Name _____ MI _____
Address _____ City _____ State_____ Zip _____
Telephone (Home) _____ (Work) _____
Birthdate _____/_____/_____ Age _____ Gender _____F _____M Race _____
Name of Spouse/Guardian _____ Phone _____
Address _____ City _____ State _____ Zip _____
Person Responsible for Payment _____ Soc. Sec. # _____
Signature of Person Responsible for Payment X _____ (Must be signed for services to begin)

EMERGENCY INFORMATION

In case of emergency, contact:
Name (1) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____
Name (2) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____
Physician _____ Phone _____
Address _____ City _____ State _____ Zip _____
Psychiatrist _____ Phone _____
Address _____ City _____ State _____ Zip _____
Other Physicians _____ Phone _____
Current Medications _____
Allergies _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Phone _____ Hrs _____
Spouse: Place _____ Phone _____ Hrs _____

INSURANCE INFORMATION

Primary Insurance _____
Phone_____
Contract/ID# _____
Group/Acct#_____
Subscriber_____
Subscriber Date of Birth_____
Client's relationship to Subscriber
___Self ___Spouse ___Child ___Other_____

Secondary Insurance _____
Phone_____
Contract/ID# _____
Group/Acct# _____
Subscriber _____
Subscriber Date of Birth_____
Client's relationship to Subscriber
___Self ___Spouse ___Child ____Other_____

PROVISIONS: Client pays $_____ Deductible amount Amount satisfied: $_____
Insurance pays_____ % for visits____–____ and_____ % for visits____–____
Type(s) of providers covered: _____ Supervision: _____
Prior authorization needed: _____
Effective date: _____ Policy anniversary: _____
Coverage for testing: _____ Annual limit: _____

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REFERRAL SOURCE

How did you hear of our clinic (or from whom)? _____
Address _____ City _____ State _____ Zip _____
Phone _____ Relationship to referral source _____