Daniel P. Huerta MSW, LCSW, LLC 5585 Erindale Dr.; Suite 105 Colorado Springs, CO 80918
(719) 502-9992

General Information Form

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY** Readmit: __Yes __No

Date_____ Client's Social Security #_____

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)

Estimated Annual Household Income: $_____ (for Medicaid or Sliding Scale clients)

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 and Dosages_____

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_____ Secondary Insurance_____

Phone_____ Phone_____

Contract/ID#_____ Contract/ID#_____

Group/Acct#_____ Group/Acct#_____

Subscriber_____ Subscriber_____

Subscriber Date of Birth _____ Subscriber Date of Birth_____

Client's relationship to Subscriber Client's relationship to Subscriber

__Self __Spouse __Child __Other_____ __Self __Spouse __Child __Other_____

Referral Source

How did you hear of our clinic (or from whom)?_____