Child & Adolescent Psychiatry Consulting DBA

EMPOWER MENTAL HEALTH CLINIC

empowermhc.com ▢ 2001 S. Central Ave. Ste. A, Marshfield, WI 54449 ▢ 715-384-2818

New Client Form

Client's Name:_____ Date of Birth:_____
Address:_____City_____State_____Zip_____
Home Phone:_____ Cell Phone: _____ Email:_____
(If patient is a Child) School:_____Grade:_____ Teacher:_____
Spouse/Parent/Guardian Name: _____ Date of Birth:_____
Address:_____City_____State_____Zip_____
Home Phone:_____ Cell Phone: _____ Email:_____
Emergency Contact:_____*Phone:*_____*Relationship:*_____

For appointment reminders, please: ☐ Call ☐ Text ☐ Email ☐ I prefer not to receive reminders
May we leave voice messages? ☐ Yes ☐ No
Appointment Preference? ☐ In Person ☐ Telehealth ☐ First Available

Primary Insurance Provider: _____ID#: _____ Group#: _____
Subscriber Name: _____ Subscriber DOB: _____
Secondary Insurance Provider: _____ID#: _____ Group#: _____
Subscriber Name: _____ Subscriber DOB: _____

Guarantor/Responsible Financial Party *(will receive statements and be responsible for balances)*
Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____
Name: _____ Date of Birth:_____
Address:_____City_____State_____Zip_____
Phone:_____ Email:_____

Date of Referral: _____**Agency/Person Referred by:**_____
Reason for Referral:_____

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OFFICE USE ONLY: Insurance Verified ☐ Contacted for Scheduling ☐ Intake Scheduled ☐