DAYSPRING COUNSELING SERVICES
CLIENT INTAKE FORM

NAME of New Patient(s):
ADDRESS:
Contact Telephone Number**:**
Contact Email Address:
Date(s) of BIRTH:
If Patient is child, Child's Name:
Child's Date of Birth:
If New Patient is a student, Name of School:
If using Insurance:
Insurance Company:
Effective Date of Insurance:
Telephone number on reverse of card for Mental Health Benefits:
Insurance ID#:
Insurance Subscriber Name:
Insurance Subscriber Date of Birth:
Co-Pay Amount:
Deductible with Insurance: Yes or No
If Deductible, how much has been met?
Co-Insurance/Percentage Based : Yes or No
Are Authorizations Needed to see a Mental Health Professional? Yes or No
Authorization Number if applicable:
Preferences:
Male or Female Therapist, or does not matter?
Would you be willing to see an Intern?
Appointment Hours/Days available**:**
Are you available in the morning or lunch time?
Can you go to our Paoli Office if no openings in Exton?

How did you hear about Dayspring:

Brief History/Reason for contacting Dayspring:

For Office Use Only:
Appointment: Y or N Date of First Appt.: _____
Info Forwarded to Therapist: Y or N/Therapist Name: _____ Date Forwarded: _____
Appt. Conf. Email Sent: Y or N/ Date Email Sent: _____ Time Email Sent: _____