TAIT COUNSELING & CONSULTING

New Client Referral Form

Today's Date: _____ Adult (_____) / Child (_____)

Last Name_____ First Name: _____

Date of Birth: _____/_____/_____ Your Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____)_____ Work Phone: (____)_____

Cell Phone: (____)_____ Email address: _____

Mailing Address (If different from above): _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: (Name)_____ (Phone)_____

Relationship Status:
Married: ☐ Single: ☐ Divorced: ☐ Separated: ☐ Widowed: ☐ Living With Significant Other: ☐

Name of Spouse (if applicable): _____

If under 18, **Name of Parents/Guardians: _____**

Please check your insurance provider:
Blue Cross Blue Shield of Georgia: ☐ Aetna: ☐ Humana ☐ Care Source: ☐ Other: _____ ☐

Address for Claims: P.O. Box_____Payer ID# _____
Insured's Phone # _____ DOB: _____
Insured Name: _____ Employer: _____ Group: _____
Insurance ID # _____ Co-Pay:_____

Return To:

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