Kristin Roberts, LCSW
Phone: (865) 774-2444 FAX: (865)774-4235

419 High Street
Sevierville, TN 37862

Adult Intake Information

Date _____ **Dx** _____
Ct. # _____

Name_____ Today's Date _____
last first m.i.

Address_____
number street apt.# city state zip

Home Phone_____ Work Phone _____ Extension _____

Cell Phone_____ Email address_____

Social Security Number_____-_____-_____ Birth Date _____ Age _____

Sex: M F other_____ Relationship/Marital Status: (circle one) Sing. Mar. Sep. Div. Wid. Partner

Driver's License#_____ State _____

Employer _____ Job Title/Occupation_____

Work Address_____
number street suite# city state zip

Spouse's/Partner's Name _____ Birth Date _____ Age_____ SSN _____

Spouse's Employer _____ Occupation _____ Cell Phone _____

Primary Care Physician _____ Phone _____

Emergency Contact (Not within the same household) Name _____

Relationship to you _____ Home Phone _____ Cell Phone _____

Children and ages_____

Insurance Information / **EAP Information when applicable**

If you plan to use insurance benefits, have you pre-authorized these visits through your insurance company?

☐ Yes ☐ No Authorization number _____

Name of Insured _____Your relationship to the Insured: Self Spouse Other

Primary Insurance/EAP Company _____ Insured's Date of Birth _____

Deductible: Amount _____ Met? _____ Co-Pay _____

Copy of insurance card attached. Yes _____ Not yet _____ Not needed _____

Referral from: Name_____IMD___ PhD___ LCSW ___ Other___

AUTHORIZATION FOR COMMUNICATION WITH REFERRAL SOURCE: My signature below indicates my permission for Kristin Roberts, LCSW. and the referral source listed above to communicate verbally and/or in writing as they think necessary for the benefit of my treatment.

Client Signature_____ Date_____