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INTAKE EVALUATION

Identifying Information

Client's Name: _____ Today's Date: _____

Parents' Names (if applicable): _____

Address: _____ City, State, Zip: _____

Telephone #: Hm _____ Wk _____ Cell _____

Gender: M F Age: _____ Date of Birth: _____ Marital Status: _____

Occupation: _____ Employer: _____

Social Security (ID) Number: _____ Referred By: _____

Emergency Contact: _____ Phone #: _____

Briefly state purpose of today's visit: _____

Insurance Information

PRIMARY INSURANCE

Name of Insured: _____ Insured's Date of Birth: _____

Address of Insured Person: _____ City, State, Zip _____

Relationship of Client to Insured Person: _____

Insured Person's Employer: _____

Insurance Company: _____ Ins. Phone #: _____

Insurance Company Address: _____ City, State, Zip _____

Insurance Identification Number _____ Group Number: _____

SECONDARY INSURANCE

Name of Insured: _____ Insured's Date of Birth: _____

Address of Insured Person: _____ City, State, Zip _____

Relationship of Client to Insured Person: _____

Insured Person's Employer: _____

Secondary Company: _____ Ins. Phone #: _____

Secondary Company Address: _____ City, State, Zip _____

Secondary Identification Number _____ Group Number: _____

Signature: _____

Date: _____