DATE:________________
Client ID#_____________
Provider:______________

# CLIENT FACE SHEET

***Information requested on this form is essential data for our record and program planning. Your answers are kept in strictest confidence and never released to any other agency or individual without your written consent. PLEASE PRINT and COMPLETE ALL FIELDS.***

## Patient Information

Patient Last Name: __________________________ First Name: _________________________ Middle: _____ __Male __Female __Other

___New Client ___ Returning Client MARITAL STATUS: S M Div Sep Wid

SSN: _________________________ Parent/Guardian (if client is a minor): _________________________

Is this your legal name? __Y __N If not, what is your legal name? _________________________ Birth date: _______________ Age:_______

Street Address: ______________________________________________ City: __________________________ State: _________ Zip: _________________

Email: ______________________________________________________ Home Phone: ________________ Cell Phone: _____________________________

Authorized method of contact (check all that apply): ___Email ___Home Phone (ok to leave message? _Y _N) ___Cell Phone (ok to leave message? _Y _N) ___Other (ok to leave message? _Y _N)

EMERGENCY CONTACT NAME: _______________________________ Emergency Contact Phone: _________________________

___*Check here if you are required to have an authorized representative for decision making*

Military Status: ___Former ___Current ___NA
U.S. Citizen: ___Y ___N Ethnic Origin:___________________________

Race: __Am Indian or Alaska Native ___Asian ___White ___Black ___Multicultural ___Pacific Islander ___Other

Education: ___HS/GED ___Associate's ___Bachelor's ___Master's ___Advanced

Employment Status: ___Full-Time ___Part-Time ___Unemployed ___Retired ___Disabled

Female Headed Household? ___Y ___N

# of people in household: _______ # of children under 18:____ # of disabled dependents:___
# of elder dependents: ____ # of unemployed dependents:____

## REFERRAL INFORMATION

How did you hear about Shara Smile? ______________________________________________________________________________________
I'd like to hear more about workshops, groups and events at Shara Smile: ___Y ___N

## AGREEMENT

***The information above is true and complete to the best of my knowledge. I understand none of the above will be shared outside of Shara Smile without my prior written consent.***
***Patient/guardian signature:*****________________________________________________________ *DATE:*______________________________**

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