



1759 West Broadway St., Suite 3  
Oviedo, FL 32765  
Phone: 407-977-4335 Fax: 407-977-4370

**SCREENING INFORMATION**

**Please Print Clearly**                      **THIS SHEET MUST BE FILLED IN COMPLETELY**                      Readmit:  Yes     No

Date \_\_\_\_\_ Client's Social Security # \_\_\_\_\_ Client RCC ID # \_\_\_\_\_

Client's First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

E-mail: \_\_\_\_\_

Does RCC have your permission to e-mail appointment confirmations?  Yes/ No                      Initials: \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Gender  F  M    Race \_\_\_\_\_

Name of Spouse/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Address (if different than above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

**Emergency Information**

In case of emergency, contact:

Name (1) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Current Medication(s) & Dosage(s) \_\_\_\_\_

Allergies \_\_\_\_\_

**Employment Information** (If client is a child, use parent's employment)

Client/Guardian: Place \_\_\_\_\_ Phone \_\_\_\_\_ Hours \_\_\_\_\_

Spouse: Place \_\_\_\_\_ Phone \_\_\_\_\_ Hours \_\_\_\_\_

**Insurance Information**

Primary Insurance \_\_\_\_\_ Phone \_\_\_\_\_

Contract/ID# \_\_\_\_\_ Group/Acct# \_\_\_\_\_

Subscriber \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Client's relationship to Subscriber

Self     Spouse     Child     Other \_\_\_\_\_

**Referral Source**

How did you hear of us (or from whom)? \_\_\_\_\_