

WINGS
Client Information Sheet

Admission status: _____ Voluntary _____ Court Order _____ Other

Admission Date: _____ Time: _____ Client DOB _____

Name _____ Nickname: _____

SS# _____ Gender _____ Place of Birth: _____

Home Address _____ City _____ State/Zip _____

County _____ Home Phone# _____ Cell # _____

Religion: _____ Language(s) spoken /Written _____

*DOB of Primary Insurance Holder: _____ Relationship to Client _____

*(Only needed if client has private insurance)

Race or Cultural Heritage (Circle one)

_ Hispanic/Latina _ American Indian _ Asian _ Black/African _ Native Pacific Islander _ White

Tribal Affiliation, if Any: _____

Height _____ Weight: _____ Hair color: _____ Eye Color: _____

Tattoos/Piercings _____

Allergies to Foods or Medications

Do you have any of the following: Eye Glasses Contacts Hearing aides Retainer
Bridges Braces

Emergency Contacts

1. Name: _____ Relationship _____

Home # _____ Work # _____ Cell # _____

Address _____

2. Name: _____ Relationship _____

Home # _____ Work # _____ Cell # _____

Address _____

3. Name: _____ Relationship _____

Home # _____ Work _____ Cell _____

Address _____

Legal:

Probation Officer: _____

County: _____ Phone # _____ Fax # _____

Address: _____

Social Worker: _____

County: _____ Phone # _____ Fax # _____

Address: _____

Rule25 Assessor: _____

County: _____ Phone # _____ Fax # _____

Address: _____

Guardian adlitem: _____

County: _____ Phone # _____ Fax # _____

Address: _____

WINGS
Resident Face Sheet

Insurance Information:

Primary Insurance Company Name _____

Card Holder Name (Client Name) _____

ID # _____ Group # _____

Policy Holder Name: _____ DOB _____ SS# _____

Secondary Insurance Company Name _____

Card Holder Name _____

ID # _____ Group # _____

Policy Holder: _____ DOB _____ SS# _____

Medical Assistance

Policy # _____ County: _____

Case Worker: _____ Phone # _____ Fax # _____

Medical

Primary Physician _____ Clinic Name: _____

Phone # _____ Fax # _____ Address _____

Dentist _____ Clinic Name: _____

Phone # _____ Fax # _____ Address _____

Eye Dr. _____ Clinic Name: _____

Phone # _____ Fax # _____ Address _____

Mental Health Provider _____ Clinic Name: _____

Phone # _____ Fax # _____ Address _____

Other Medical Professionals: _____ Clinic Name _____

Address _____ Fax# _____ Phone _____

Signature & Title _____ **Date** _____

Place Photo Here

