# NEW CLIENT INFORMATION

Date:___________________________

Have you been to the Helping Department of Jewish for Good before? (formerly known as Jewish Family Services) _____Yes _____No

Was Jewish for Good chosen because it was a Jewish agency? _____Yes _____ No

Reason for contacting Jewish for Good:

___________________________________________________________________________

Name:

___________________________________________________________________________

Religion: ____________________________ Sex: _________ Race: ____________________
Birthdate:_____________________

Marital Status: _________________________ Email Address: _____________________________________________

Address:

___________________________________________________________________________

City: ________________________________________ State: _____ Zip: ___________

Phone(H): _______________________ Phone(W): ______________________ Phone(C): ___________________

Please circle your preferred method of contact: email, phone (H), phone (W), phone (C). May we leave a message? Y/N

Please circle one: Employed Unemployed Retired Other:______________________________

Referred By:

___________________________________________________________________________

Reason for referral:

___________________________________________________________________________

Employment Information:

Occupation/School:

___________________________________________________________________________

Name of Employer:

___________________________________________________________________________

Medical Information and Insurance (For Counseling and Case Management Clients ONLY)

Primary Care Physician: _____________________________________________Phone: ___________________________

Preferred Hospital/Clinic: ______________________________________________
City:___________________________________

Do you have insurance? Yes__________ No ___________

Primary Insurance

Insurance Carrier #1 _____________________________________ Name of Policy Holder:_________________________________

Policy #: ____________________________ Group #: ________________________ DOB of Policy Holder: _____/______/______

Secondary Insurance

Insurance Carrier #2 _____________________________________ Name of Policy Holder:_________________________________

Policy #: ____________________________ Group #: ________________________ DOB of Policy Holder: _____/______/______

---

Emergency Contact Information

In case of emergency, who should be notified?

Name: ______________________________________________________________________

Address: ______________________________________________________________________

Phone(H): ________________________________ Phone(W): ____________________________________________

Relationship:_____________________________________________________________________

## *Composition of Family Household*

Please list other household members:

| Name | Relationship | Date of Birth | Religion | Sex | Race |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |