WellSpring Renewal Services, Inc.
Stanislaus Commons
2608 Vineville Ave
Suite 207
Macon GA 31204
478-960-5475

SCREENING INFORMATION

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY** Readmit: __Yes __No

Date_____ Client's Social Security #_____ PCS ID #_____

Client's First Name_____ Last Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____

Birth date_____/_____/_____ Age_____ Gender __F __M Race_____

Email Address: _____ Reminder Calls Requested? _____ Phone: _____

Name of Spouse/Guardian_____ Phone_____

Address_____ City_____ State_____ Zip_____

Person Responsible for Payment_____ Soc. Sec. #_____

Signature of Person Responsible for Payment **X**_____ (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship_____ Phone_____Work_____
Address_____ City_____ State_____ Zip_____

Name (2) _____ Relationship_____ Phone_____Work_____
Address_____ City_____ State_____ Zip_____

Physician_____ Phone_____
Address_____ City_____ State_____ Zip_____

Psychiatrist_____ Phone_____
Address_____ City_____ State_____ Zip_____

Other Physicians_____ Phone_____

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Current Medications_____

Allergies_____

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

Client/Guardian: Place_____ Phone_____ Hrs_____

Spouse: Place_____ Phone_____ Hrs_____

Insurance Information

Primary Insurance_____

Phone_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber Date of Birth _____

Client's relationship to Subscriber

☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary Insurance_____

Phone_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber Date of Birth_____

Client's relationship to Subscriber

☐ Self ☐ Spouse ☐ Child ☐ Other_____

Referral Source

How did you hear of our clinic (or from whom)?_____

Address_____ City_____ State_____ Zip_____

Phone_____ Relationship to referral source_____

Additional Notes: