Baker Street
Behavioral Health

Client Prequalification Form

Date of Inquiry: _____ Received by: _____

CLIENT INFORMATION

Name:	DOB:	Gender: ☐ M ☐ F
Mailing Address:		
City:	State:	Zip Code:
Cell #:	Alternate #:	
Email Address:	Mom:	Date:

INSURANCE INFORMATION

Insurance Company:		Phone:
Member ID #:	Group #:	
Mailing Address:		
City:	State:	Zip Code:
Name of Primary Insured:	DOB:	Gender: ☐ M ☐ F
Address:		
City:	State:	Zip Code:
Client Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Partner ☐ Parent ☐ Other		
Client Relationship to Insured: ☐ Yes ☐ No	Medicare: ☐ Yes ☐ No	Medicaid: ☐ Yes ☐ No
Issues/Concerns:		

Requesting Clinician:	Preferred Gender of Clinician:	* Location: Virtual or In-Office
Client Availability:		
Service Needed: ☐ Individual Therapy ☐ Group Therapy ☐ Speech ☐ Testing ☐ Med Mgmt		
How did you hear about us?		