Agency Headquarters: 2005 Asbury Rd
Dubuque, Iowa 52001
563-583-7357

Mark which location(s) you are requesting. All locations provide counseling; (♦) denotes medication management services are available at this site. Fax, mail or drop off (during normal business hours) your intake packet directly to that location. Allow up to three (3) business days for our office to verify insurance eligibility and plan benefits.

Dubuque Locations

☐ **Asbury MHC**
2005 Asbury Rd.
Dubuque, IA 52001
PH: 563-583-7357
Fax: 563-583-7026

☐ **Crescent MHC**
1789 Elm St.
Dubuque, IA 52001
PH: 563-583-7357
Fax: 563-583-7026

☐ **Mercy MHC ♦**
PAP Bldg.
200 Mercy Dr., Suite 200
Dubuque, IA 52001
PH: 563-582-0145
Fax: 1-888-526-5456

☐ **Solutions MHC ♦**
5900 Saratoga Plaza
Dubuque, IA 52002
PH: 563-231-3521
Fax: 563-231-3522

☐ **Unity Point Dubuque**
4170 Pennsylvania Ave
Dubuque, IA 52002
PH: 563-583-7357
Fax: 563-583-7026

☐ **Unity Point Peosta**
8456 Peosta Commercial Ct.
Peosta, IA 52068
PH: 563-583-7357
Fax: 563-583-7026

Northeast Locations

☐ **Maquoketa MHC ♦**
117 S. Olive St.
Maquoketa, IA 52060
PH: 563-652-4958
Fax: 563-652-2418

☐ **Unity Point Cascade MHC**
610 2nd Ave NE
Cascade, IA 52033
PH: 563-583-7357
Fax: 563-583-7026

☐ **Jones MHC ♦**
818 W 1st St., Suite 100
Monticello, IA 52310
PH: 319-844-1119
Fax: 319-844-1121

Southeast Locations

☐ **Washington MHC ♦**
2175 Lexington Blvd, Bldg. 2
Washington, IA 52353
PH: 319-653-6161
Fax: 319-863-1311

☐ **Henry MHC ♦**
106 N Jackson St.
Mt Pleasant, IA 52641
PH: 319-385-7177
Fax: 319-385-9567

☐ **Louisa MHC ♦**
220 N Second St.
Wapello, IA 52653
PH: 319-527-4455
Fax: 319-527-4458

☐ I would like counseling services.

☐ I would like medication management services.

If you need to speak to someone before you are contacted to set up your appointment, please utilize our Crisis Recovery Team at1-855-800-1239 OR call 9-1-1.

☐ New ☐ Update

Hillcrest Family Services
Demographic Form

Client Status: ○ **Pre-Registered** ○ **Admit**

Client Legal Name:_____
(Last) *(First)* *(MI)* *(Suffix)*

Alias/Maiden Name:_____
(Last) *(First)* *(MI)*

Client Address:_____

City/State/Zip:_____ **County:**_____

Mailing Address *(if different)*:_____

City/State/Zip:_____

OK to send mail? ○ **Yes** ○ **No** ○ **Unknown**

Primary Phone #:_____ ○ Home ○ Cell

Preferred means of communication (Appointment Reminders): ○ **Phone call** ○ **Text** ○ **None**

Work Phone #:_____

Other Phone #:_____ ○ Home ○ Cell

Special Calling Instructions:_____

Email Address:_____ **Ok to send e-mail?** ○ **Yes** ○ **No**

Client Legal Status: ○ **Adult** ○ **Adult with Guardian** ○ **Minor with Guardian** ○ **Emancipated Minor**

Legal Guardian Name:_____ **Relationship to Client:**_____

Address:_____

City/State/Zip:_____ **Phone:**_____

Does Client have an Emergency Contact? ○ **Yes** ○ **No**

Emergency Contact Name:_____ **Relationship to Client:**_____

Address:_____

City/State/Zip:_____ **Phone:**_____

Date of Birth:_____ **Gender:** ○ **Male** ○ **Female** ○ **Transgender**

Social Security #:_____ Reason why SS# not provided:_____

Race:_____ **Marital Status:**_____ **Ethnicity:**_____

Language:_____ **Religion:**_____ **Is this person in special education:** ○ **Yes** ○ **No**

Last Grade Completed:_____ **School:**_____

Interpreter needed? ○ **Yes** ○ **No** **School District:**_____

Employment Status:_____ **Household Income:**_____

Living Arrangement:_____ **Household Composition:**_____
(Foster care, group home, etc.) *(Single adult, significant other, etc.)*

Does Client have an Advance Directive? ○ **Yes** ○ **No**

Smoking Status: ○ Current, everday smoker ○ Current, some day smoker ○ Former smoker ○ Never smoker ○ Smoker, current status unknown ○ Unknown if ever smoked

Client Name:______________________________ **SS#:**______________________ **DOB:**_______________

Relationship Information *(Household Members Detail)*

Relationship:______________________________ If other, please specify:______________________________

Name:___________________________________ **DOB:**_______________ **Gender:**____________________

Address *(If different)*:____

City/State/Zip:____

Home Phone:_________________________________ **Work Phone:**_______________________________

Relationship:______________________________ If other, please specify:______________________________

Name:___________________________________ **DOB:**_______________ **Gender:**____________________

Address *(If different)*:____

City/State/Zip:____

Home Phone:_________________________________ **Work Phone:**_______________________________

Relationship:______________________________ If other, please specify:______________________________

Name:___________________________________ **DOB:**_______________ **Gender:**____________________

Address *(If different)*:____

City/State/Zip:____

Home Phone:_________________________________ **Work Phone:**_______________________________

Relationship:______________________________ If other, please specify:______________________________

Name:___________________________________ **DOB:**_______________ **Gender:**____________________

Address *(If different)*:____

City/State/Zip:____

Home Phone:_________________________________ **Work Phone:**_______________________________

Referral Source:___________________________ **Referral Information:**________________________________

Presenting Problem:

Scheduling Requirements:____

Did the Client Provide the Information? ○ **Yes** ○ **No**

Name of person providing information *(if not the client)*:____

Relationship to Client:______________________________ **Phone Number:**______________________________

Name & Employee ID of Person Obtaining Information:

____ _________________ ____________

Name Employee ID Date Time

Name & Employee ID of Person Entering Information:

____ _________________ ____________

Name Employee ID Date Time

Hillcrest Family Services
Client Insurance Form

Client Name:_____ **Date:**_____

Primary Insurance:

Insurance Name:_____ **Policy Number:**_____

Insurance Phone #:_____

Group Number:_____ **Name:**_____

Policy Holder Information **If self, please indicate and skip rest of section*

Relationship to Insured:_____**Name:**_____

Address:_____

City/State/Zip:_____

Date of Birth:_____ **Sex:**_____

Secondary Insurance: *(If applicable)*

Insurance Name:_____ **Policy Number:**_____

Insurance Phone #:_____

Group Number:_____ **Name:**_____

Policy Holder Information **If self, please indicate and skip rest of section*

Relationship to Insured:_____**Name:**_____

Address:_____

City/State/Zip:_____

Date of Birth:_____ **Sex:**_____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical and/or government benefits either to myself or to the party who accepts assignment below.

Signed:_____ **Date:**_____