



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

- | | | |
|---|--|---|
| <input type="checkbox"/> Asbury MHC
2005 Asbury Rd.
Dubuque, IA 52001
PH: 563-583-7357
Fax: 563-583-7026 | <input type="checkbox"/> Mercy MHC ♦
PAP Bldg.
200 Mercy Dr., Suite 200
Dubuque, IA 52001
PH: 563-582-0145
Fax: 1-888-526-5456 | <input type="checkbox"/> Solutions MHC ♦
5900 Saratoga Rd. Suite 11
Dubuque, IA 52002
PH: 563-231-3521
Fax: 563-231-3522 |
|---|--|---|

Northeast Locations

- | | |
|---|--|
| <input type="checkbox"/> Maquoketa MHC ♦
117 S. Olive St.
Maquoketa, IA 52060
PH: 563-652-4958
Fax: 563-652-2418 | <input type="checkbox"/> Jones MHC ♦
818 W 1 st St., Suite 100
Monticello, IA 52310
PH: 319-844-1119
Fax: 319-844-1121 |
|---|--|

Southeast Locations

- | | | |
|---|--|---|
| <input type="checkbox"/> Washington MHC ♦
2175 Lexington Blvd, Bldg. 2
Washington, IA 52353
PH: 319-653-6161
Fax: 319-863-1311 | <input type="checkbox"/> Henry MHC ♦
106 N Jackson St.
Mt Pleasant, IA 52641
PH: 319-385-7177
Fax: 319-385-9567 | <input type="checkbox"/> Louisa MHC ♦
218 N 2nd St.
Wapello, IA 52653
PH: 319-527-4455
Fax: 319-527-0009 |
|---|--|---|

- 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 at 1-855-800-1239 OR call 9-1-1.



Hillcrest Family Services Demographic Form

New Update

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, everyday 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: _____