

CLIENT CONTACT INFORMATION SHEET

BERLINE LAPOMAREDE SAFE HAVEN CLINICAL AND ADVOCACY SERVICES

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Serving Clients In Florida

CONTACT INFORMATION

Name: _____

Birth Date: (MM/DD/YYYY) ____/____/____

Age: ____

Gender: _____

Pronouns: _____

Email: _____

May We Send You An Email?

Yes: ____ **No:** ____

Primary Phone: (____) ____ - ____

Secondary Phone: (____) ____ - ____

May We Leave A Voicemail?

Yes: ____ **No:** ____

Address: _____

City: _____

State: ____ **Zip:** _____

OCCUPATION INFORMATION

Employer: _____

Work Phone: (____) ____ - ____

May We Call this Number?

Yes: ____ **No:** ____

Job Title: _____

Address: _____

City: _____

State: ____ **Zip:** _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____

Email: _____

Phone: (____) ____ - ____

May We Call this Number?

Yes: ____ **No:** ____

PLEASE NOTE:

**EMAIL CORRESPONDENCE IS NOT CONSIDERED TO BE A CONFIDENTIAL MEDIUM OF COMMUNICATION
UNLESS SENT USING AN ENCRYPTED SERVER.**