CLIENT INFORMATION

Client Name__________________________________Marital Status_____Date_________________

Street Address__________________________________City____________ State_ __Zip_________

Birthdate______________ SS#_______________Phone(home)_______________ (work)___________

Employer___________________________________ Address_________________________________

If someone other than the client is responsible for the bill, provide name, address, employer, **and signature** of person responsible: ___________________________

____

Name of person to be contacted in case of emergency________________________________

Relationship to client__________________ Phone (h)_______________(w)_______________

Complete this section only if using insurance:

__Client's primary insurance________________________________ Contract #_______________

Insured's name__________________________Insured's relationship to client___________

Insured's address____________________________ Insured's employer____________________

Other insurance____

Who referred you to me?______________________________ Address________________________

Phone_____________________________Sign on next line to give permission to send a thank-you note to the referring person____

Sign here to give permission to exchange relevant clinical information* with the referring person ____

If not referred, how did you find me?____

Primary care physician____

Address_______________________________ ________________Phone ____________________

Sign here to give permission to exchange clinical information* with this physician:

____

*(Treatment summaries, progress reports, and phone contact as needed)

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