Client Information Form

Today's date:_____

Identification

Your name:_____ Date of birth:_____ Age:_____

Social Security #:_____

Home address:_____

Phone #:_____ E-mail:_____

Is it ok to leave messages for you via phone and/or e-mail?_____

Referral

Who gave you my name to call?_____

Address:_____ Phone: _____

May I have your permission to thank this person for the referral? _____

Primary concern or reason for your appointment today?_____

_____

_____

Your Medical Care

Clinic/doctor's name:_____ Phone:_____

Address:_____

Insurance Information

Patients name: _____
Patients date of birth: _____ Paient's SS#:_____
Policy holder's name (if different from patient):_____
Policy holder's date of birth:_____ Policy holder's SS#:_____
Policy holder's employer:_____
Name of Insurance:_____
Policy #:_____ Group #:_____ Expiration date:_____
Add
Address to mail claims:_____

Phone # for providers:_____

Name of any behavioral health subcontractor:_____
Phone # of behavioral health subcontractor:_____

Employment

Current employer:_____ Work Phone:_____

Address:_____

Emergency Information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name:_____ Phone:_____

Address:_____