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Client Information Form

All statements and office correspondences will be sent to the address below unless otherwise indicated. Please indicate if you do not want a message left at the numbers you have provided below.

Patient's First/Last Name:____
Date of Birth:________________________
Address:____
City, State, ZIP Code:_____________________________________
Home phone number:____________________
Cell phone number:_____________________
Email Address:____
Emergency name/contact number:____________________________________
Relationship to Patient:____
If minor: Mother's Name:_________________ Father's Name:____________________
Name(s) of all legal Guardian (s):____
Financially responsible party:____________________________
Patient relationship to the policyholder:(circle one) self spouse child other:________
Insured person's information:
Insured person/responsible party name:________________________________
Address(if different from above):_______________________________________
Insured Date of Birth:_______________Insured SS#:__________________
Insurance Company Name/Number:_______________________________
Insured ID:____________________Group#:____________________________
Employer of Policyholder:_________________Insurance effective date:____________
Name of provider you are seeing today:_______________________________________
Who referred you to the provider you are seeing today?____________________________ Do you want your clinician to communicate information with your primary care physician (PCP)? Yes:____ No:_____(PCP is your internist, pediatrician or family physician, not your psychiatrist).
Do you have secondary insurance? Yes___No:______
Our office Does not bill secondary insurance companies. This is the responsibility of the client. We will provide all information for the client to bill secondary insurance company directly.