Client Information Form

Client Name_____ New Client? ☐ Client Update? ☐
Must be full, legal name of the person being seen for therapy

Address _____ _____ _____ _____
Street or PO Box City State Zip

Social Security Number_____ Date of Birth_____ Gender ☐ M ☐ F

Home Phone _____ ☐ Y ☐ N
May I leave a message?

Work Phone _____ ☐ Y ☐ N
May I leave a message?

Other Phone_____ ☐ Y ☐ N
Please identify May I leave a message?

Client Marital Status
☐ Single ☐ Married ☐ Other

Client Employed?
☐ Yes ☐ No

Client Student Status
☐ Full Time ☐ Part Time

Email:_____

How Did You Hear About My Practice? ***Please be as specific as possible***

Name _____ ☐ Former/Current Client ☐ Yellow Pages ☐ Internet

☐ Healthcare Professional ☐ Mental Health Provider ☐ Insurance Company ☐ Word of Mouth

Responsible Party Information ***The responsible party will receive the bill for any services not covered by insurance. Please complete any information that differs from the client.***

Name_____ Home Phone_____

Address_____ Work Phone_____
Street or PO Box

_____ Relationship to Client:_____
City State Zip

Insurance Information ***Information in this section should pertain to the Primary Person listed on the insurance card. Please complete any information that differs from the client.***

Insurance Co_____ Insurance Phone#_____

Insured's Name_____ ID#_____

Group#_____ Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Address _____ Home Phone_____
Street or PO Box

_____Insured's SSN_____
City State Zip

Insured's DOB_____ Gender ☐ M ☐ F Insured's Employer_____

I hereby authorize the release of all information necessary to secure payment and assign all benefits to which I am entitled.

Signature_____ Date_____

Office Use Only Therapist: _____ Diagnosis Code_____

Billing Notes_____

Form v1.1