

CLIENT INFORMATION FORM

Name: _____

Address: _____

Phone Number (s): _____

Your Birthdate: _____

Social Security Number: _____

Primary Insurance Carrier: _____ ID# _____

Name of Insured: _____ Group # _____

Insured's Date of Birth: _____ Insurance Phone #: _____

Secondary Insurance Carrier: _____ ID# _____

Name of Insured: _____ Group # _____

Insurance Phone #: _____

Assignment of Benefits: If you want your insurance benefits paid and sent directly to me, please sign here: _____ Date: _____

Primary Physician: _____

Medications taken routinely? (Please List and include dosage, if possible)

Have you seen another mental health practitioner within the last six months? Yes ___ No ___

Who referred you to me? _____