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NEW CLIENT INFORMATION

Date: _____

CLIENT Name: (first, middle, last)_____

Date of birth:_____Social Security #:_____

Address:_____City:_____ State: _____Zip: _____

Phone (Cell):_____ (Home): _____(Office): _____

Email *(optional)*_____

Occupation:_____Employer:_____

Employer's Address:_____ City _____ State_____ Zip _____

Employer's Address:_____ City _____ State_____ Zip _____

Marital Status: _____Single _____Married _____Separated _____Divorced _____Widowed _____SO/Fiancé

If applicable, please list:

Spouse/SO Name: (first, middle, last)_____

Date of birth:_____Social Security #:_____

Address:_____City:_____ State: _____Zip: _____

Phone (Cell):_____ (Home): _____(Office): _____

Email *(optional)*_____

Occupation:_____Employer:_____

Employer's Address:_____ City _____ State_____ Zip _____

If Client is a minor, please complete the following:

	Mother	Father
Name:	_____	_____
Date of Birth:	_____	_____
Social Security #:	_____	_____
Address:	_____	_____
	_____	_____
Phone:	(Home)_____(Cell)_____	(Home)_____(Cell)_____
	(Office)_____(Other)_____	(Office)_____(Other)_____
Email:	_____	_____
Occupation:	_____	_____
Employer:	_____	_____
Employer's	_____	_____
Address:	_____	_____

We try to contact clients by phone, ***TEXT message or email a day in advance to remind them of their appointments.*** There may be other contacts needed as well. Please list below the number(s) and/or email address by which you prefer to be contacted. If you wish, you may opt out of this service. Simply write "Do not contact" in the space below.

Text Mobile#:_____ Call Phone#:_____Email: _____

May we leave a message on voicemail for you if you do not answer? Y or N

Please list the First and Last names of individuals with whom we may leave a message if you do not answer:_____

(continued on reverse side)

Insurance Information

(leave blank if we made a copy of your card)

	Primary Insurance:	Secondary Insurance:
Insurance Company:	_____	_____
Policy Number:	_____	_____
Group Number:	_____	_____
Phone Number:	_____	_____
Name of Policy Holder:	_____	_____
Date of Birth of Holder:	_____	_____
Address:	_____	_____
Relationship to Client:	_____	_____
EAP Authorization#:	_____	_____

Responsible Party Information

Please provide the following information on the person responsible for payment of the Client's bill, if different from Client or policy holder(s):

Name (first, middle, last)_____

Date of Birth_____ Social Security # _____

Address _____ City _____ State ____ Zip_____

Phone (Home)_____ (Work) _____ (Cell) _____

Occupation _____

Employer _____

Employer's Address _____

_____

Emergency Notification

Please provide the name of a relative or friend, whom can be contacted in the case of an emergency:

Name (first, middle, last) _____

Address _____City _____ State ____ Zip _____

Phone (Home) _____(Work) _____ (Cell)_____

Relationship to Client:_____