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CLIENT DATA SHEET

Name:_____Age:_____ Date of Birth:_____
Street Address:_____
City: _____ State:_____ Zip Code:_____
Home/Cell Telephone:_____ OK to leave a message? _____
Work Telephone: _____ OK to leave a message? _____
Email: _____
Occupation: _____
Who referred you?_____
Emergency Contact: _____Telephone: _____
Relationship: _____
Name of your Insurance Company: _____
Subscriber Name: _____Group Name: _____
Policy #: _____Relationship to Subscriber: Self___Child___Spouse_____
Did you receive prior authorization? _____
Do you have other insurance? No _____Yes_____ If yes:
Company: _____Policy #: _____
Group Name: _____Policy Name:_____
Billing Address: _____
Person responsible for bill, if not yourself: _____
Relationship: _____Telephone: _____
Address:_____
What brings you here today?_____
_____
Previous Treatment: Please indicate when, where, and with whom:_____
_____
_____
Hospitalizations: List when, where, and nature of problem:
Medical:_____
Psychiatric: _____
Are you currently being treated for any medical conditions? No _____Yes _____
If yes, please list:
Physician Condition Treatment
_____
_____
_____
_____
Are you taking any medications not listed above? Please list: _____
_____
Have you ever taken any medications for emotional issues? If yes, please list:_____
_____
Who is your primary care physician?_____Telephone_____
Have you ever undergone treatment for any serious or chronic illness? If yes, please specify:
_____
I certify that the information provided is accurate. I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

Client Signature: _____Date: _____
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