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*

☐ Former/Current Client ☐ Healthcare Professional ☐ Yellow Pages ☐ Mental Health Provider

☐ Insurance Company ☐ Word of Mouth ☐ Internet ☐ Other Name _____

Responsible Party Information *The responsible party will receive the bill for any services not covered by insurance. Please only complete 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 only complete 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 v1.0