Dx Codes: _______, _______, _______ (Provider Only)

CLIENT INFORMATION

Client Name: ____ Age: ________ Date of Birth: ______________________________

Social Security #: __________________________________ Gender ______________ Marital Status_______________________

Home Address: ____

____

Home Phone: _______________________ Cell #: ___________________________ Work # ______________________________

Email: ____Employer: ____

Occupation: _________________________________. Employer City and State ____

Person Responsible for Payment: ______________________________________ Relationship: _______________________________

Social Security #: ___________________________________ Date of Birth: ______________________________

Address (if different from above): ____

____

Home Phone: ______________________ Cell #: _________________________ Work # :_________________________________

Parent / Spouse / Partner's Name: ___________________________________ Work Phone: _________________________________

Emergency Contact: _______________________________________ Relationship: ____

Emergency Contact numbers: ____

Referred by: ____

Primary Care Physician: ____ Phone #: ________________________________

Address: ____

There are times when I may need to contact you to reschedule an appointment or return your call. Please tell me how you would like me to contact you.

Home Phone Number:
Ok to call Yes or No ______
OK to leave message Yes or No _____

Work Phone Number:
Ok to call Yes or No _____
Ok to leave message on this number Yes or No ______

Cell Phone Number:
Ok to call Yes or No ______
Ok to leave message Yes or No__________
Ok to text Yes or No_________ I do not have HIPAA compliant texting (extra encryption) so you are agreeing it is ok to text without the extra encryption.
Ok to email: Yes or No _______________-

To file insurance I must have the following information:

Insurance Company Name ____ Phone: ______________________________

Name of Insured: ____ Employer: ____

Social Security #: _______________________________________ Date of Birth: ____

Policy # ____ Effective Date: ____