Client Information Form

Client Name_____ New Client? Client Update? _____
Must be full, legal name of the person being seen for therapy

Spouse/SO Name_____

Address _____ _____ _____ _____
Street or PO Box City State Zip

Social Security Number_____ Date of Birth_____ Gender M◯ F◯ Other◯

Social Security Number_____ Date of Birth_____ Gender M◯ F◯ Other◯

Cell Phone _____

Cell Phone _____

Email:_____

Email:_____

Client Marital Status
Single◯ Married◯ Other◯

Client Employed?
Yes◯ No◯

Client Student Status
Full Time◯ Part Time◯

How Did You Hear About My Practice?_____

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_____

Change in Insurance Information or Change of Address

_____

_____

_____

I hereby authorize the release of all information necessary to secure payment and assign all benefits to which I am entitled.

Signed_____ Date _____

Office Use Only Therapist: **Meredith Manker LPC, PA** Diagnosis Code_____

Billing Notes_____

Form Date: 10-15-09