CLIENT INFORMATION

PLEASE FILL IN AS COMPLETELY AS POSSIBLE AND PRINT CLEARLY

Date: ______________ Client #:

Client's First Name: __________________ Last Name: ________________________

Address: __________________ City: __________________ State: ____ Zip: _____

Telephone: (home) ____________________ (cell) _________________________

E-Mail: ______________________________

Birthdate: __________________ Age: ________ Gender: M ___ F ___

Would you like a text or e-mail reminder? TEXT or E-MAIL (circle one)

If a text, who is your carrier? (ex, Verizon) __________________________

Emergency Contact Information:

Contact Name: ________________________ Relationship:_____________________

Phone: (Best) _____________________ (Alternate) _______________________

Full Address: ____

Primary Care Doctor: _________________________ Telephone: ________________

Psychiatrist: ________________________________ Telephone: ________________

Current Medications: ____

Allergies: ____

Insurance Information:

Primary Insurance: ________________________ ID# _________________________

Name of Subscriber: _______________________ Date of Birth: _________________

Co-pay amount: $__________ (or) Private Pay Rate: $__________ (or)

Deductible:______________________Employer:________________________________

Signature of Person Responsible for Payment: ______________________________

I understand that all appointments not cancelled within the required 24 hours are subject to the $50 cancellation/no show fee.

X____