NEW CLIENT INFORMATION

CLIENT'S NAME: _____ TODAY'S DATE: _____

PRONOUNS: _____ DATE OF BIRTH: _____ AGE: _____

GENDER (listed on insurance): _____ MARITAL STATUS:_____ EMAIL: _____

HOME ADDRESS: _____CITY / STATE / ZIP: _____

Primary PHONE: (_____) _____Alternate PHONE: (_____)_____

STUDENT STATUS: _Non Student _Full Time _Part Time _Unknown EMAIL: _____

REFERRED BY: _____.

What is the Relationship of Person Filling Out This Form to the Client: _____

Person financially responsible for payment of services and / or subscriber of the primary insurance plan:

SUBSCRIBER: _____ CLIENT NAME ON INSURANCE: _____

HOME ADDRESS_____ CITY / STATE / ZIP: _____

HOME PHONE: (_____) _____ BUSINESS PHONE: (_____)_____

OCCUPATION / TITLE: _____ EMPLOYED BY: _____

SUBSCRIBER DATE OF BIRTH: _____POLICY ID NUMBER: _____

INSURANCE COMPANY: _____PLAN NAME / GROUP NUMBER: _____

INSURANCE ADDRESS: _____ADDRESS LINE 2: _____

CITY / STATE / ZIP: _____PHONE NUMBER: _____

FAX PHONE NUMBER: _____ IPA / HMO NAME: _____

SUBSCRIBER RELATIONSHIP TO PATIENT: _Self _Parent _Spouse _Dependent _Other

EMPLOYMENT: _ Full Time _ Part Time _ Not Employed _ Unknown _ Retired/ Date: _____

IS CLIENT COVERED BY ANY OTHER INSURANCE POLICY YES NO .

Below For Office Use Only:

Services : Individual ☐ Family ☐ Group ☐ Collateral ☐ Other _____ Co Pay: _____

Diagnosis: Code: _____ Description: _____ DSM-5/ICD10

Diagnosis: Code: _____ Description: _____ DSM-5/ICD10