NEW CLIENT INFORMATION

Last Name: _____ First Name: _____ MI:___
Date: _____ Referred by: _____
DOB: _____ Age: _____ Sex: M / F
Address: _____
_____
Home Phone: _____ Work Phone: _____ Cell: _____
SSN: _____
Employer: _____
Nearest Relative Living Outside your Home: _____
Address and phone: _____
Other family members/significant others that you want to be involved in the treatment: Names: DOB:

_____ _____
_____ _____
_____ _____

INSURANCE INFORMATION:
Insurance Name: _____ Phone: _____
Policy Number: _____ Group Number: _____
Subscriber: Last Name:_____ First name: _____ _ MI: ___
SSN: _____ DOB: _____ Relationship to client: _____
Home Address if different from client: _____
_____

EMPLOYEE ASSISTANCE INFORMATION:
Are you eligible for EAP benefits? Yes / No
Employer:_____
Have you called for your initial authorization: Yes / No
Authorization Number: _____

Reason for Seeking Mental Health Services: _____
_____
_____
_____

If requested, I will make every effort to provide reminder calls for scheduled appointments. Please indicate here whether or not you would like to receive these calls or have any special instructions for these calls.

_____
_____

Patient Signature: _____ Date: _____
Guardian/Parent: _____
(Signing Parent or Guardian of Minor is Responsible for Incurred charges.)