Joseph T. Wilkinson, LICSW
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Client Insurance & Demographic Form

Client Information

Client Name: _____ DOB: ___/___/___ SSN ____ __ ____

Gender: ☐ Male ☐ Female ☐ Other _____ Marital: ☐ Single ☐ Married ☐ Other

Student: ☐ FT ☐ PT Employed: ☐ FT ☐ PT ☐ Unemployed

Address: _____

City, State, Zip: _____

Phone (H): _____ (C): _____ (W): _____

Email: _____

Employer: _____ Phone: _____

Employer Address: _____

Primary Care Provider: _____ Referred By: _____

Emergency Contact

Name: _____ Relationship: _____

Phone (H): _____ (C): _____

Address: _____

City, State, Zip: _____

Responsible Party (if client is a minor)

Name: _____ DOB: ___/___/___ SSN (Last 4): _____

Gender: ☐ Male ☐ Female Phone: _____ Email: _____

Address: _____

City, State, Zip: _____

Primary Insurance Info

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder: _____ DOB: ___/___/___ SSN ___ __ ____

Gender: ☐ Male ☐ Female Employer: _____ Phone: _____

Insurance Co: _____ Plan: _____

ID #: _____ Group #: _____

Effective Date: ___/___/___ Insurance Phone: _____

Military Status: ☐ N/A ☐ Active ☐ Retired ☐ Discharged ☐ Deceased

Secondary Insurance (if any)

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder: _____ DOB: ___/___/___ SSN ___ __ ____

Insurance Co: _____ Plan: _____

ID #: _____ Group #: _____

Effective Date: ___/___/___ Insurance Phone: _____

Authorizations

☐ Assignment of Benefits: I authorize insurance payments to be sent directly to Joseph T. Wilkinson, LICSW. I understand I am financially responsible for charges not covered by insurance, including copays, deductibles, no-show fees, or out-of-network charges.

☐ Release of Info: I authorize the release of information necessary to process claims and determine benefits.

☐ Medicare/Medicaid: I authorize payment and release of information to process related services.

Signature: _____ Date: ___/___/___

☐ Client ☐ Parent ☐ Guardian