Dr. Jackie Jiang & Associates
Phone: 309-944-7833 Fax: 309-403-0554

Client Demographic Information

Referred by: _____

Client Name (First, Middle Initial, & Last): _____

Home Address: _____

Date of Birth: _____ Social Security Number (SSN): _____

Cell Phone #: _____ Home Phone #: _____

Leave a message on your answering machine? ☐ Yes ☐ No

Leave a message with a family member? ☐ Yes ☐ No

Adult Client (if client is a minor, skip to the "Minor Client" section below):

Place of Employment: _____ Job Title: _____

Employment Address: _____

Work Phone #: _____

Marital Status: ☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Widowed

Name of Spouse/Partner (please circle one; if applicable): _____

Home Address (if different): _____

Date of Birth: _____ SSN: _____

Cell Phone #: _____ Home Phone # (if different): _____

Place of Employment: _____ Job Title: _____

Child(ren) Name(s) and Age(s): _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Minor Client (if client is an adult, please skip this section):

School: _____ Grade: _____ Major (if applicable): _____

Primary Care Physician: _____ at _____

(Please see the back side of this page)

Financial Responsibility

Responsible party for payment will be: ☐ Client/Self ☐ Mother ☐ Father ☐ Other: _____

Responsible party contact information (if different from above):

Name (First, Middle Initial, & Last): _____
Home Address: _____
Date of Birth: _____ SSN: _____
Cell Phone #: _____ Home Phone #: _____
Place of Employment: _____ Job Title: _____
Employment Address: _____
Work Phone #: _____

Insurance(s) Information

***You may *skip* this section if you submitted a copy of your insurance card(s). Please Sign Below.**

Primary Insurance Company: _____
Employer: _____
Policy Holder Name: _____ SSN: _____ DOB: _____
Address: _____
Group ID Number: _____ Group Number: _____
Policy Number: _____
Pre-Authorization Number: _____ Number of Sessions: _____

Secondary Insurance Company: _____
Employer: _____
Policy Holder Name: _____ SSN: _____ DOB: _____
Address: _____
Group ID Number: _____ Group Number: _____
Policy Number: _____

☐ I hereby authorize my/my child's insurance company to make payments directly to **Dr. Jackie Jiang & Associates** for professional services rendered, and I shall be personally responsible for any unpaid balance to the clinician. I understand a service charge of 1.5% (18% per year) may be added to any outstanding balance more than 30 days old.

☐ I do **not** wish my insurance to be billed and/or I will pay for services rendered. I understand a service charge of 1.5% (18% per year) may be added to any outstanding balance more than 30 days old.

Signature: _____ Date: _____