Client Information Form

First Name: _____MI __ Home Phone: ( ) _____-_____
Last Name: _____ Cell Phone ( ) _____-_____
Address: _____ Work Phone: ( ) _____-_____
_____ Birth Date / /
City, State, Zip: _____ Sex: ____Male ____Female
Employer: Previous Counseling: ____Yes ____No
Marital Status: ____S ____M ____Other Email: _____
Employment Status: ____F/T ____P/T ____Retired ____Not Employed
Student: ____F/T ____P/T ____Not Student

RESPONSIBLE PARTY (if other than client)

First Name: _____ MI Home Phone: ( ) _____-_____
Last Name: _____ Work Phone: ( ) _____-_____
Address: _____ Birth Date / /
Sex: ____Male ____Female
City, State, Zip: _____

Use additional forms if there are additional responsible parties.

INSURANCE INFORMATION

Ins. Name: _____ Phone: ( ) _____-_____
Address: _____
_____
City, State, Zip: _____

Policy Holder: _____ ID Number: _____
First Name: _____ Policy Number: _____
Last Name: _____ Group Number: _____
Date of Birth: _____ Effective Date: _____
Authorization: _____
Relationship to Insured: ____Self ____Spouse ____Child ____Other
Under employer's Health Plan? ____Yes ____No Visit Limit _____
Insurance Plan Name: _____ Payer ID: _____
Employer's Name: _____
Signature: **Date:** _____

How did you hear about us? _____

Use additional forms if there are additional insurance companies.