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Client Information

Today's Date_____

CLIENT _____ **(DOB)** _____ **Phone (H)** _____

ADDRESS _____ **Phone (W)** _____

City _____**Zip**_____**Phone (cell)** _____

E-mail _____

May I send correspondence or leave messages?

Home address	□YES	□NO	**Cell Phone**	□YES	□NO
Home Phone	□YES	□NO	**Email**	□YES	□NO

Emergency Contact Information, Name and Phone

_____ _____

_____ _____

How were you referred to me? _____

Billing Information

PERSON RESPONSIBLE FOR PAYMENT _____ **(DOB)** _____ **Phone (H)** _____

RELATIONSHIP TO PATIENT _____**Phone (W)** _____

ADDRESS _____ **Phone (cell)** _____

_____

SS # _____ **EMPLOYER** _____

WILL YOU BE USING YOUR INSURANCE? ☐ **YES** ☐ **NO**

Insurance Co _____**Group ID**_____ **Policy Number**_____

Secondary Insurance? ☐ **YES** ☐ **NO** _____

****A COPY OF YOUR INSURANCE CARD IS REQUIRED <u>BEFORE ANY CLAIMS CAN BE FILED</u>**

PRESENTING PROBLEM: _____
