Client Information Sheet

Please Print

CLIENT NAME:	DATE OF BIRTH: GENDER: PREFERRED PRONOUNS:
HOME ADDRESS:	MARITAL STATUS:
CITY AND ZIP CODE:	WORK ADDRESS:
HOME PHONE	CITY AND ZIP CODE:
WORK PHONE:	MOBILE PHONE:
EMAIL ADDRESS:	***Referred By:***

INSURANCE

Primary Insurance Company:	Secondary Insurance Company:
Subscriber Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other	Subscriber Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Insured ID Number:	Insured ID Number:
Group Number:	Group Number:
Copayment Amount:	**Deductible:**

MISSED OR CANCELLED APPOINTMENTS

I understand that there will be a charge for missed or cancelled appointments if less than 24 business hours notice is given. I give permission for my credit card on file to be charged for missed appointments.

ASSIGNMENT AND RELEASE

I hereby authorize the release of information necessary to file a claim with my insurance company and for insurance benefits to be paid directly to________________. I understand that I am financially responsible for any unpaid balance, including deductible and co-payment. A copy of the signature is as valid as the original.

Signature:	Date:

Please list any medications:

Please list any health or medical issues:

Current use of drugs or alcohol: