CLIENT INFORMATION FOR COUPLES/FAMILY THERAPY

(Please print)

DATE _____

1st CLIENT INFORMATION

Last Name _____

First Name _____

Address _____

City _____

State _____ Zip Code _____

Home Phone (____) _____

Business Phone (____) _____

Cell Phone (____) _____

Marital Status S M D W

Sex Female _____ Male _____

Date of Birth _____

Social Security # _____

E-Mail address _____

Relationship to Insured (Circle One)

SELF SPOUSE CHILD OTHER

2ND CLIENT INFORMATION

Last Name _____

First Name _____

Address _____

City _____

Sate _____Zip Code _____

Home Phone (_____) _____

Business Phone (_____) _____

Cell Phone (____) _____

Marital Status S M D W

Sex Female _____ Male _____

Date of Birth _____

Social Security # _____

E-Mail Address _____

Relationship to Insured (Circle One)

SELF SPOUSE CHILD OTHER

INSURANCE INFORMATION

Insurance Co. Name _____

Insurance Co. Address _____

City _____

State _____Zip Code_____

Insurance Co. Phone (_____)_____

Policy Identification # _____

Policy Group # _____

Policy Group Name _____

Secondary Insurance Coverage YES NO

POLICY HOLDER INFORMATION

Last Name _____

First Name _____

Name of Referring Physician or Friend _____

FOR OFFICE USE ONLY:

Therapist _____ TH _____ DX_____

Name of Client To Be Billed For Insurance _____