CLIENT INFORMATION

CLIENT NAME (FIRST, MI, LAST):_____ DOB:_____

IF A CHILD: MOM:_____ DAD:_____ GUARDIAN:_____

CLIENT ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____ EMAIL: _____

HOME PHONE:_____ SS# OF RESPONSIBLE PARTY _____

CELL PHONE:_____ WHOSE PHONE IS THIS?_____

OTHER PHONE:_____ WHOSE PHONE IS THIS?_____

CIRCLE ALL THAT APPLY REGARDING THE CLIENT:

MALE FEMALE

SINGLE MARRIED DIVORCED WIDOWED

EMPLOYED UNEMPLOYED NOT EMPLOYED

FULL-TIME STUDENT PART-TIME STUDENT NOT A STUDENT

IS THERE A **GUARDIAN AD LIETEM** INVOLVED AT ALL?

YES No

PRIMARY INSURANCE

INSURANCE COMPANY NAME:_____

ID #_____

INSURED'S NAME:_____ RELATIONSHIP TO CLIENT:_____

INSURED'S BIRTHDAY:_____ INSURED'S PHONE#_____

INSURED'S ADDRESS (IF DIFFERENT FROM CLIENT):_____

CITY:_____ STATE:_____ ZIP:_____

EMPLOYERS NAME:_____

SECONDARY INSURANCE

INSURANCE COMPANY NAME:_____

ID #_____

INSURED'S NAME:_____ RELATIONSHIP TO CLIENT:_____

INSURED'S BIRTHDAY:_____ INSURED'S PHONE#_____

INSURED'S ADDRESS (IF DIFFERENT FROM CLIENT):_____

CITY:_____ STATE:_____ ZIP:_____

EMPLOYERS NAME:_____

I authorize payment of medical benefits to the undersigned physician claims for the visits at this office.

******SIGNED:_____ DATE:_____******