CLIENT INFORMATION FORM

Client's Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip Code:_____ Sex: M F

Home Phone: _____ Work: _____ Cell: _____ Email: _____

Are there any restrictions or specific instructions for contacting you at these numbers? _____

Social Security #: _____-_____-_____ Date of Birth:_____/_____/_____ Age: _____ Marital Status: _____

Name of Employer (*or school if minor*): _____

Employer (*or school*) Address: _____

Employer (*or school*) Phone #: _____

If client is a minor, name of responsible party: _____

Responsible Party Address (*if different from above*):_____

Responsible Party Phone #s: Home: _____ Work: _____

Who referred you?: _____

INSURANCE INFORMATION

_____ *I have no insurance at this time or am choosing not to use my insurance at this time. I will be paying out-of-pocket for services rendered.*
(Mark with an "X")

Primary Insurance

Name of Insured _____ Date of Birth: _____/_____/_____

Address of Insured (*if different from above*): _____

Insured's Social Security #: _____-_____-_____ Insured's Insurance I.D. Number: _____

Insurance Company Name: _____ Group or policy #: _____

Insurance Company Address: _____Phone #: _____

Insured's Employer: _____ Phone #: _____

Secondary Insurance (if applicable)

Name of Insured (*if different from above*): _____ Date of Birth: _____/_____/_____

Address of Insured (*if different from above*): _____

Insured's Social Security #: _____-_____-_____ Insured's Insurance I.D. Number: _____

Insurance Company Name: _____ Group or policy #: _____

Insurance Company Address: _____Phone #: _____

Insured's Employer: _____ Phone #: _____

Name of Spouse/Partner:
Name: _____ Phone #: _____

If patient is a minor:
Parent's Names in household:

Name: _____ Phone #: _____
Name: _____ Phone #: _____

Siblings or Children at home or away:

Name: _____ Age: _____ Name: _____ Age: _____
Name: _____ Age: _____ Name: _____ Age: _____

Other Relevant Medical Concerns:

Current Medical Concerns (including duration and treatment received): _____

_____

_____

Name of Doctor: _____ Phone #: _____

Address: _____

Last time seen by your physician: _____ Date of last physical: _____

List prescribed medications that you are currently taking: _____

Name of Psychiatrist, if applicable: _____ Date of last evaluation: _____

List prescribed medications you are currently taking: _____

I hereby authorize Stacy L Perkins, M.A., LCPC, Ltd. and those she hires for the purposes of insurance billing, to furnish my insurance company all information which they may request concerning my care. I hereby assign to Stacy L Perkins, M.A., LCPC, Ltd. all monies to which I am entitled for expenses relative to the services received. I understand that I am financially responsible to said Stacy L Perkins, M.A., LCPC, Ltd. for charges not covered by this assignment.

Insured/Parent/Guardian _____ Date _____