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Confidential Client Information Form

Client Name: ____

Last Name **First** **Middle**

Date of Birth:_______________ **Age**_______ **SS#**___________________ **Male/Female**

Address:____ **Apt #:**_________

City:______________________________**State:**__________**Zip Code:**____________

Home Phone:________________________ **Cell Phone:**_________________________

Email address: ____

Marital Status: **Single** **Married** **Divorced** **Separated** **Widowed**

Primary Insurance Co:___________________________ **Phone #:**_________________

ID#___________________________ **Group #**________________________

Policyholder's Name:____________________ **SS#**________________**DOB:**________

Auth#_______________________ **# visits** _____ **Date range**_____________________

Deductible__________ **Met?**________ **Co-insurance %**__________ **Co-pay**__________

Secondary Insurance Co:_________________________ **Phone#**____________________

ID#___________________________ **Group#**________________________

EAP Provider____________________________ **Phone #** ________________________

Auth#_______________________ **# visits** _____ **Date range**_____________________

Emergency Contact:______________________________ **Relationship:**_____________

Home #_____________________________ **Cell #** ______________________________

I am responsible for payment of all services rendered according to the insurance benefits.

____ **Date:**______________

Signature of client/ parent or legal guardian