NEW CLIENT INFORMATION

PATIENT'S NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____

HOME PHONE: (_____) _____ BUSINESS PHONE: (_____)_____

☐ CELL ☐ PAGER: _____ PATIENT SOCIAL SECURITY: _____

STUDENT STATUS: ___ Non-Student ___ Full-Time ___ Part-Time ___ Unknown

EMAIL ADDRESS: _____

REFERRED BY: _____ RELATIONSHIP TO CLIENT: _____

ADDRESS :_____ CITY / STATE / ZIP: _____

PHONE: (_____) _____ FAX: (_____)_____

What is the Relationship of Person Filling Out This Form to the Patient:

(Person financially responsible for payment of services and / or subscriber of the primary insurance plan)

SUBSCRIBER: _____ SOCIAL SECURITY NUMBER: _____

HOME ADDRESS: _____ CITY / STATE / ZIP: _____

HOME PHONE: (_____) _____ BUSINESS PHONE: (_____)_____

OCCUPATION / TITLE: _____ EMPLOYED BY: _____

SUBSCRIBER DATE OF BIRTH: _____ POLICY ID NUMBER: _____

INSURANCE COMPANY: _____ PLAN NAME / GROUP NUMBER: _____

INSURANCE ADDRESS: _____ ADDRESS LINE 2: _____

CITY / STATE / ZIP: _____ IPA / HMO NAME: _____

PHONE: (_____) _____ FAX: (_____)_____

SUBSCRIBER RELATIONSHIP TO PATIENT: ___ Self ___ Parent ___ Spouse ___ Dependent ___ Other

EMPLOYMENT: ___ Full-Time ___ Part-Time ___ Unemployed ___ Unknown ___ Retired - Retired Date: _____

Person to Contact in Case of Emergency:

NAME: _____ RELATIONSHIP TO CLIENT: _____

HOME PHONE: (_____) _____ BUSINESS PHONE: (_____)_____

CELL PHONE: (_____) _____