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Psychologist

New Client Information Form

Client Information

Name: _____
Address: _____
City: _____
State: _____
Zip: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____
Fax Number: _____

Client Specific Information

Social Security Number: _____
Date of Birth: _____ Age: _____

In case of emergency please contact:
_____

Relationship: _____
Phone Number: _____

Gender: ☐ Female ☐ Male
Occupation: _____
Employer: _____

I am under a doctor's care for:
_____

Doctor's Name: _____
Doctor's Phone: _____
Medications: _____

Insurance Information

Insurance Company: _____
Insurance ID #: _____

Does your insurance require prior authorization of services? ☐ Yes ☐ No

First Authorization #: _____
Insurance comp. phone #: _____

Claims Address:
_____
_____
_____

Relationship to Insured:
☐ Parent/Child ☐ Self ☐ Spouse

If insured is other than self, please complete the following:

Name: _____
Social Security #: _____
Date of Birth: _____
Employer: _____
Employer Address: _____
City, State, Zip: _____

Contact Information

May we send written materials to your home? ☐ Yes ☐ No

May we email you? ☐ Yes ☐ No

May we leave a discreet message:

On your home phone? ☐ Yes ☐ No
At your work phone? ☐ Yes ☐ No
On your cellphone? ☐ Yes ☐ No

How did you hear about us?
☐ Insurance Company ☐ Friend ☐ Client of ours
☐ Website ☐ Yellow Pages ☐ Doctor/Professional
☐ Other _____

Person who referred you: _____

May we thank this person for their referral?_____
Address: _____
_____

Psychologist to Complete

COUNSELING:
☐ Individual
☐ Couples
☐ Group
☐ A.D.D.

1. We file Insurance Claims ☐ Yes ☐ No
2. Authorization Required ☐ Yes ☐ No
3. DIAGNOSIS CODE: ☐ Yes ☐ No