Client Information Form

Primary Client *(the "patient" for Insurance purposes)*		**Client #2** *(for couples, family therapy or if 'patient' is not 'owner' of insurance)*
	Full Name	
	Date of Birth, Age, Gender	
	Home Phone	
	Work Phone- IF OK to call	
	Cell phone	
	email	
	Mailing address	
	Marital status	
	Dependents with names and ages	
	Occupation	
	Income	
	Education	
	Faith Tradition	
	Emergency Contact	
	Referred By?	
	Doctor(s) contact info	
	Medications	
	Insurance: Authorization #, Deductible, Copay	
	Social Security #	
	for Office Use only: DX, CPT	