

# Confidential Client Information

## Personal Information

NAME: \_\_\_\_\_ GENDER (M/F): \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Separated  Widowed  Live as Married

EMPLOYER/SCHOOL: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

OK to call:  Home  Work  Restrictions on messages: \_\_\_\_\_

## Other Members of the Household

NAME : \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

NAME : \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

NAME : \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

NAME : \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

## Medical Information

PHYSICIAN: \_\_\_\_\_ DATE OF LAST VISIT: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

REFERRED TO THIS OFFICE BY: \_\_\_\_\_

CURRENT MEDICATIONS & DOSAGES: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

CURRENT MEDICAL PROBLEMS OR TREATMENT: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

# Insurance Information

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RESPONSIBLE PARTY & INSURANCE INFORMATION

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RESPONSIBLE PARTY/INSURED: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

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HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP : \_\_\_\_\_

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EMPLOYER ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP : \_\_\_\_\_

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HEALTH INSURANCE CARRIER: \_\_\_\_\_ PHONE: \_\_\_\_\_

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INSURANCE ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

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IDENTIFICATION#: \_\_\_\_\_ GROUP #: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

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DEDUCTIBLE AMOUNT: \_\_\_\_\_ HAS DEDUCTIBLE BEEN MET (Y/N): \_\_\_\_\_ BENEFIT %: \_\_\_\_\_ CO-PAY/CO-INS \$: \_\_\_\_\_

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PREAUTHORIZATION REQUIRED (Y/N): \_\_\_\_\_ CONTACT NUMBER FOR PREAUTHORIZATION: \_\_\_\_\_

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DESCRIBE LIMITS/RESTRICTIONS ON COVERAGE: \_\_\_\_\_

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SIGNATURE OF CLIENT OR PARENT/LEGAL GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

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PLEASE REQUEST A SECOND FORM IF YOU HAVE SECONDARY INSURANCE: \_\_\_\_\_

## Office Use Only

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DX CODING PRIMARY: \_\_\_\_\_ SECONDARY: \_\_\_\_\_

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NOTES: \_\_\_\_\_

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