

INITIAL CLIENT INFORMATION

Date:

Name DOB: SSN:

Home Phone Work Phone Cell Phone

Email How to reach you Marital Status

Address City State Zip

Emerg. Contact Relationship Phone

Employer Person organization who referred you

Medical Clinic City Medical Provider

Communication between health care providers can be beneficial to your receiving services and establishing continuity of care. Your permission is required for this communication. Please check one of the following:

- I do not have a primary health care provider.
- No**, I do not want communication with my primary health provider
- Yes**, I want communication with my health care provider (Letter or phone call indicating you have been seen at this location).

Your Signature: Date:

For parents or guardians: I attest that I have the legal authority to request and permit the above named person to be seen and treated. Signature: Date:

Primary Insurance Company Policy Holder

Policy Number Employer/Group # SSN

Secondary Insurance Company Policy Holder

Policy Number Employer/Group # SSN

Failure to provide timely information about your health insurance can result in you being totally responsible for the cost of services provided. Many insurances require billing to be done in a "timely manner" and will not pay claims submitted after the allotted time.

How would you like to be contacted for reminder calls for follow up appts and reminder calls. Please check and provide the appropriate information.

Text: Number to text to:

Phone: Number to call:

Email: email: