

Associates in Psychotherapy

CLIENT INFORMATION SHEET

Today's Date:			
PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	Social Security Number:
Address:	City:	State:	Zip Code:
Home Phone:	Mobile/Work Phone:	Which phone number is the best one to reach you?	Any restrictions on phone calls or messages? ___Y___N
Do you want to receive Appointment Reminders? ___Y___N	If yes, by Email or Text?	Email Address:	How did you hear about our practice?
Date of Birth:	Age:	Marital Status:	Sex:
Parent/Guardian Last Name:	First Name:	Home Phone:	Mobile/Work Phone:
Address:	City:	State:	Zip Code:
INSURANCE INFORMATION			
(Please provide me with a copy of your insurance card)			
Name of Insurance:	Name of Insured:	Relationship to Client:	Date of Birth of Policyholder:
Social Security Number of Insured:	Policy Number:	Group Number:	
Address of Policyholder:	City:	State:	Zip Code:
Home Phone:	Mobile/Work Phone:		
IN CASE OF EMERGENCY			
Emergency Contact:	Relationship to Client:	Home Phone:	Mobile/Work Phone:
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Michelle Chaban, P.C. I understand that I am financially responsible for any balance. I also authorize Michelle Chaban, P.C. or the insurance company to release any information required to process my claims.</p>			
<hr/> Patient/Guardian signature		<hr/> Date	