



Client Name: \_\_\_\_\_

Client Date of Birth: \_\_\_\_\_ Client's Relation to Insured: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Employer/Union: \_\_\_\_\_

Insured's Soc. Sec. #: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Client's Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Can a Message Be Left? Yes \_\_\_\_\_ No \_\_\_\_\_ Special Instructions: \_\_\_\_\_

Client's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insured's Address (If Different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is Patient Married? \_\_\_\_\_ Length of Marriage: \_\_\_\_\_

If Not Married, With Significant Other? \_\_\_\_\_ Length of Relationship: \_\_\_\_\_

Number of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider Licensure #: \_\_\_\_\_

Provider Phone: \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_