CLIENT INFORMATION

NAME_____ DATE OF BIRTH_____ SS # _____
(LAST, FIRST (MIDDLE INITIAL)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Email _____ May we contact you via Email? Yes No

PLACE OF EMPLOYMENT: _____

Work Telephone # _____ May we call you at this number? Yes No May we leave a message? Yes No

Home Telephone # _____ May we call you at this number? Yes No May we leave a message? Yes No

EMERGENCY CONTACT # _____ May we call you at this number? Yes No May we leave a message? Yes No

SPOUSE INFORMATION

NAME_____ DATE OF BIRTH_____ SS # _____
(LAST, FIRST (MIDDLE INITIAL)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Email _____ May we contact you via Email Yes No

PLACE OF EMPLOYMENT: _____

Work Telephone # _____ May we call you at this number? Yes No May we leave a message? Yes No

Home Telephone # _____ May we call you at this number? Yes No May we leave a message? Yes No

EMERGENCY CONTACT # _____ May we call you at this number? Yes No May we leave a message? Yes No

How did you find out about this office? _____

What are the major issues that have caused you to seek professional help?

_____

Have you/family member ever been treated for the same/similar problem? If yes, when _____ By Whom _____

My primary care physician is _____ Date of last physical exam _____

List all medications that you are currently taking and for what treatment they are prescribed:

_____

_____

List all members of family living with you (names, ages and their relationship to you)

_____

_____

Who will be responsible for the payment? _____

NAME OF INSURANCE COMPANY _____ ID # _____ GROUP # _____
I want my insurance billed for all visits. YES _____ NO _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO AUTHORIZE AND REQUEST PAYMENT OF BENEFITS TO BE MADE DIRECTLY TO JOHN MAYBERRY, LMFT, FOR SERVICES RENDERED ON MY BEHALF OR ON THE BEHALF OF MY DEPENDENTS. _____ Initials

I UNDERSTAND THAT I AM RESPONSIBLE FOR OBTAINING ANY NECESSARY PRECERTIFICATION OR REFERRALS REQUIRED BY MY INSURANCE COMPANY. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES WHICH ARE NOT PAID BY MY INSURANCE COMPANY. _____ Initials

(SIGN) _____ DATE_____