CLIENT INFORMATION SHEET

Patient Name: _____ **SSN#:** _____ **DOB:** _____

Address: _____**City:** _____ **State:** ___ **Zip Code:** _____

Phone No.(s): Home: _____ **Work:** _____ **Cell:** _____

Parent/Guardian Name(s) (if child): _____

Parent/Guardian Address (if different from child): _____

Parent/Guardian Phone No.(s): (if different from child): _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Domestic partner** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Ethnicity: ☐ **White/European American** ☐ **Black/ African American** ☐ **Multi-racial**

☐ **Hispanic/Latino** ☐ **Native American** ☐ **Asian American** ☐ **Other** ☐ **Prefer not to respond**

Gender: ☐ **Male** ☐ **Female** ☐ **Trans** ☐ **Other identity** ☐ **Prefer not to respond**

Emergency Contact: _____ **Phone #:** _____

INSURANCE INFORMATION (Please provide copy of card)

Primary **Policy Holder's Name:** _____ **DOB:** _____

Policy Holder's SSN#: _____ **Relationship to patient: Self** ☐ **Parent** ☐ **Spouse** ☐

Insurance Company: _____ **Phone #:** _____

Claims address: _____

Subscriber ID #: _____ **Group #:** _____

Secondary **Policy Holder's Name:** _____ **DOB:** _____

Policy Holder's SSN#: _____ **Relationship to patient: Self** ☐ **Parent** ☐ **Spouse** ☐

Insurance Company: _____ **Phone #:** _____

Claims address: _____

Subscriber ID #: _____ **Group #:** _____