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| NEW CLIENT FORM |  |
| Patient Name:  |  |
| DOB: Age:  |  Marital Status:  |
| SSN:  |  |
| Home Address:  |  |
| City:  State:  |  Zip: |
| Home Phone: | Mobile Phone:  |
| Preferred: ◻Home ◻ Cell | Email Address: |
| Referred By: |  |
| **Primary Insurance Information: *Please note that insurance information will be checked as a courtesy and can sometimes be inaccurate. We recommend you contact your insurance company regarding benefits for Outpatient Mental Health. Thank you!*** |  |
| Insurance Carrier:  | Subscriber ID: |
| Group Number:  | Mental Health Phone: |
| Subscriber’s Name: | Subscriber’s DOB: |
| Subscriber’s SSN: | Relationship to Subscriber:  |