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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: |