PLEASE PRINT

CONFIDENTIAL CLIENT INFORMATION Date:_____

Name:_____
First Middle Last

Address:_____
Number Street City State Zip

Mailing Address (If Different):_____
Number Street City State Zip

Home Phone: ( )_____Cell phone( )_____
OK to Call? o Yes o No o Yes o No
OK to Leave Message? o Yes o No o Yes o No

Date of Birth:_____ Preferred Pronouns:_____

Marital Status: Single Married Divorced Separated Widowed Partner Coupled

Client's Employer:_____ o Full Time o Part Time

Emergency contact_____ cell phone_____

Insurance Carrier:_____Type of ins. PPO EAP POS HMO

Customer Service Phone #: (usually on front of card)_____

"Mental Health" phone #, or "Provider phone #"-*: (usually on back of card)_____

I.D.Number on card_____Group Number: _____

Claims Address:_____

Policy Holder: Name:_____Policy holder's date of birth:_____

Policy holder's address- Same as above? Yes No Address:_____

Policy holder's Employer:_____

Relationship of patient to insured: Self Spouse Partner Child Other_____

RESPONSIBLE PARTY INFORMATION (If other than patient)

Name:_____

Address:_____

Home Phone: ( )_____Cell Phone: ( )_____

Relationship to Patient:_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other informaton necessary to process all claims, and I authorize payment of medical benefits to Dr. Jennifer Vanderburg, Psy.D for all services provided.

SIGNED:X_____DATE:_____