



Client Information

Name: _____ SS#: _____ Sex: ___ Date of Birth: _____

Relationship to Insured: _____ (if payment source is insurance)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

(Please check each box if permitted to leave a message on that phone number)

Email: _____

Address: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

Name: _____ SS#: _____ Sex: ___ Date of Birth: _____

Relationship to Insured: _____ (if payment source is insurance)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

(Please check each box if permitted to leave a message on that phone number)

Email: _____

Address: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

Children (if part of treatment):

Name: _____ SS#: _____ Sex: ___ Date of Birth: _____

Name: _____ SS#: _____ Sex: ___ Date of Birth: _____

Other household members and their ages: _____

Emergency Contact: _____ Phone: _____

Physician: _____ Phone: _____

Office use only:

Assigned to: _____ Date: _____ Fee: _____

Insurance Information: (Both sides of your Insurance Card needs to be copied by the Front Desk)

Insurance: Name of the Insured: _____ Provider: _____

Policy/Group #: _____ ID: _____

I authorize my insurance carrier to pay benefits associated with my care directly to Deborah Groening, MFT, Marriage and Family Therapy, Inc. and I authorize the release of information necessary to coordinate benefits, treatment, and payment.

Signature: _____ Date: _____ Signature: _____ Date: _____