Client Information Sheet

Please Print

CLIENT NAME:	Date of Birth: _____ ❑ Male ☐ Married/ CU ☐ Separated/divorced ❑ Female ☐ Single ☐ Widow(er)
HOME ADDRESS:	EMPLOYER or SCHOOL ATTENDING:
CITY AND ZIP CODE:	WORK ADDRESS:
HOME PHONE:	CITY AND ZIP CODE:
WORK PHONE:	MOBILE PHONE:
Referred By:	***Email Address:***

INSURANCE

Primary Insurance Company: Address:	Secondary Insurance Company: Address:
Subscriber: _____ (Name on ID Card) D.O.B. of subscriber _____	Subscriber:_____ (Name on ID Card) D.O.B. of subscriber _____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other	Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Insured ID Number:	Insured ID Number:
Group No./Badge No.: Subscriber Place of Employment:	Group No./Badge No.:
Copayment Amount:	**Deductible:**

MISSED OR CANCELLED APPOINTMENTS

I understand that there will be a charge for missed or cancelled appointments if less than 24 business hours notice is given.

ASSIGNMENT AND RELEASE

I hereby authorize the release of information necessary to file a claim with my insurance company and for insurance benefits to be paid directly to Dr. DiBlasio. I understand that I am financially responsible for any unpaid balance, including deductible and co-payment. A copy of the signature is as valid as the original.

Signature: Date:

Dx code: *Authorization Required Y N* *Number of Sessions:*

Previous counseling (Dates & Service Provider): _____

_____

Name of Primary Care Physician & Description of Medical Problems: _____
(Please note allergies) _____

_____

Medications: _____

_____

Current use of Drugs and Alcohol: _____

_____

_____

Dx code: *Authorization Required Y N* *Number of Sessions:*