Client Information Please Print

Today's Date: _____ Seeing: Norma Vaillette

Client Information

Last Name	First Name	M I	Home Phone	Cell Phone	Work phone

Mailing Address Street	DOB mm/dd/year	Age	SS#

City, State, Zip	Gender: F M	Marital Status: M, S, W, Div, Sep	DL #

Primary Reason for making appointment	Secondary Problem or Issue
Highest Grade Level (name of school)	Work
Medications	Email Address
Referred by	

Responsible Party Relationship to client: _____

Last Name	First Name	M I	Home Phone	Cell Phone	Work Phone

Mailing Address Street	DOB mm/dd/year	SS#

City, State Zip	Gender: F M	DL#

Email Address	Occupation
Employer	Ok to contact you at work: Y/N

Insurance Information

Insurance Company	Telephone
Mailing Address	Subscriber Name /Relation to Client
Identification #	Group #
Subscriber mailing address (if different than Responsible Party)	Subscriber DOB. SS#

Emergency Contact Information

Name (someone not living with you)	relationship	Phone number	Alternate contact number

I give consent for my counselor to contact my insurance company and release information to my insurance carrier and its agents for the purpose of providing care and securing payment. I understand that I am responsible for payment of services and charges not covered by my insurance company. I understand that payment is expected at the time of service. **I understand I need to give 24 hour notice for cancellation.**

_____ _____ _____ _____

Client Signature Date Responsible Party signature Date