

Data Sheet

Personal Information

Legal Name: _____ Preferred Name: _____

Today's Date: ____/____/____ Email Address: _____

Social Security #: _____ - _____ - _____ Date of Birth: ____/____/____ Gender: _____

Race: _____ Spiritual/Religious Preference: _____

Marital Status: _____ Spouse/Partner Name: _____

Street Address: _____ City: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

May we leave a message at: Home ____ Work ____ Cell/Other ____ Best time to reach you: _____

The preferred method for appointment reminders: _____

Emergency Contact:

Name: _____ Phone Number: _____ Relationship: _____

Referral Information:

Referred By: _____ May we thank them for their referral?: YES/NO

If not referred, how did you hear about us?: _____

Occupation:

☐ EMPLOYED ☐ UNEMPLOYED ☐ RETIRED Place of Employment: _____

How many hours do you work per week?: _____

☐ Full-Time Student ☐ Part-Time Student Name of School: _____

Highest level of education obtained: _____

Briefly describe the reason you are seeking therapy:

Insurance/Payment Information:

As the client, I.....

___ **DO NOT** wish to use insurance at this time. I will complete the Insurance Opt-Out Form.*

___ have insurance that I would like to use and will complete the Insurance Information Sheet entirely.*

** I understand that if this changes, I will inform my clinician at once. In this event, I understand that my clinician will only bill from the date of the notification of the change going forward (there will be no retroactive billing).*

Do you have medicare benefits?: YES/NO

If so, please provide your Medicare information completely on the insurance form **even if you do not intend to use it.**

Signature