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New Client Information

Please print very clearly

Client Last Name:_____ First Name_____

Name like to be called:_____Marital Status_____Sex: M○ F○

Email:_____ DOB_____Age_____

Address:_____

Home Phone:_____Cell Number_____

Which of these numbers should be used to contact you if necessary?_____

May I leave a message on this number? Yes○ **No** ○

Referred by:_____

May I write a thank you note to referral source: Yes○ No○

Briefly State Reason for Appointment:_____

If Client is a child:

If parents are divorced, who is the custodial parents:_____

If parents are divorced, name of parent not living in the home:_____

In case of emergency, please notify:

Name:_____ Phone:_____

Relationship to client_____

Financial Responsibility

Person responsible for payment of bill_____

Billing Address _____

Insurance Information: (UMR patients only)

Policy Holder's Name:_____Social Security#_____

Date of Birth_____Place of employment_____

Insurance Company_____Group#_____

Insurance Co. telephone#_____

Client's relationship to insured party:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Friedman. I understand that I am financially responsible for any balance if I am not using insurance for my payment. I also authorize Dr. Fran Friedman and my insurance company to resale any information required to process my claims.

Print Name: _____

Signature:_____ Date: _____

Witness: _____ Date_____