

Today's Date: _____

Client Name: _____
(Last) (First) (MI)

Address: _____

City: _____ State: _____ Zip: _____

Phone (H): _____ (W) _____ (C) _____

Birthdate: _____ Age: _____

Marital Status: M S D W Sex: M F

Referred By: _____ Email: _____

Client Employer: _____

Spouse's Name: _____

Spouse's Employer: _____

Spouse's Phone (W) _____ (C) _____

Name of relative or close friend, not living in the same household to contact in case of emergency.

Name: _____ Phone 1: _____ Phone 2: _____

If client is a minor, Please list information of parent or guardian

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (H): _____ (W) _____ (C) _____

Employer: _____

Relationship to the client: _____

Primary Medical Insurance

Insurance Co. Name: _____ Contract #: _____

Insured's Name: _____ Address: _____

Insured's Date of Birth: _____

Secondary Medical Insurance

Insurance Co. Name: _____ Contract #: _____

Insured's Name: _____ Address: _____

Insured's Date of Birth: _____

AUTHORIZATION: I authorize Wyette Donovan, M.S.W. to release any information acquired in the course of my treatment appropriate to insurance companies or any type of litigation. I hereby authorize payment directly to the physician the amount due me in my pending claim for medical expenses payable under terms of my insurance. I agree that any balance not covered will be paid by me personally.

Signature of Client or Guardian: _____ Date: _____

Printed Name: _____