LINDEMAN & ASSOCIATES Psychological Services

ADULT CLIENT INFORMATION

Please Print Clearly
THIS SHEET MUST BE FILLED IN COMPLETELY

Date:_____
Client's First Name:_____Last Name:_____MI

Address:_____City:_____

State:_____Zip:_____

Telephone (Home):_____(Work):_____(Cell):_____

Permission to leave a message at home? Yes,_____No_____

Email Address:_____

Birthdate:_____/_____/_____Age:_____Biological Sex: F_____M_____

Gender Identity: F_____ M_____ Pronouns: _____

Place of Employment:_____Occupation:_____

Years of Schooling: ____Work Phone:_____Permission to call you at work? Yes_No____

Please list all others who live in the household and their ages:

Name Age Name Age

_____

_____

Person Responsible for Payment:_____

Signature of Person Responsible for Payment:_____

(Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1):_____Relationship:_____Phone:_____

Address:_____City:_____State:_Zip Code:_____

Name (2):_____Relationship:_____Phone:_____

Address:_____City:_____State:___Zip Code:_____

LINDEMAN & ASSOCIATES
Psychological Services

Physician:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Psychiatrist:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Other Treating Physicians:_____ Phone:_____

Current Medications:_____

Allergies:_____

PRIMARY INSURANCE:

Insured's Name:_____ Employer:_____

Insured's Address: _____

Insurance Co/Plan:_____

Insured's DOB:_____ Insured's ID#:_____

Insured's SSN:_____ Insured's Group/Policy #:_____

SECONDARY INSURANCE:

Insured's Name:_____ Employer:_____

Insured's Address: _____

Insurance Co/Plan:_____

Insured's DOB:_____ Insured's ID #:_____

Insured's SSN:_____ Insured's Group/Policy #:_____

**** Please note: If you do not provide our office with accurate insurance information at the time of service, payment for these services will be your responsibility. Please make sure to list ALL accurate insurance information. My signature below indicates that I understand and agree with all of these statements. I certify that all information is true, accurate and complete. I agree to be personally responsible for all charges not covered by my insurance.**

Signature of Client Or Legal Guardian:_____ Date:_____

Signature of Therapist:_____ Date:_____

Signature of Psychologist:_____ Date:_____