



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: _____ Gender: F _____ M _____
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: _____