Integrative Psychology Group, LLC

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Client Information Form:

Please complete this form as fully as possible. *This information is **confidential*** and for our use only and will ***not*** be released to any person or group without your written consent. *Please print clearly*.

Today's date:_______________

Your name:________________________________Date of birth:____________________ Gender:______________

Social Security Number: __________________________ Marital Status: Married____ Single_____ Other______

Parent's name (if patient is child): ___________________ Relationship to Child: ____________________________

Local address:____Apt.:_________________

City:____State:_______________Zip: _________________________

Permanent home address (if you are a student):_________________________________Apt.:_________________

City:____State:_______________Zip: _________________________

Home/evening phone:____

Cell phone:_____________________________________ Email address: ____________________________________

Preferred method of contact? Phone:_________________Email:_________________Text:___________________

(By indicating that you may be contacted by email or text, you are acknowledging the limits of confidentiality of these methods of communication).

Name of primary insurance:____

Parent, or subscriber's name:_________________________________Subscriber's date of birth:_________________

Subscriber's address: ____ Apt.:___________________

City:__________________ State:_________ Zip:__________ Subscriber's phone number:_____________________

ID #____ Group #____

Telephone number of Insurance Company:____

Emergency Contact: Name:____Phone number:___________________

Relationship of emergency contact to self?____

How did you hear about our services?:____