



Confidential Client Information

Name: _____ Sex: M F Birth date: _____

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

Marital Status: Married Single Divorced Separated Widowed Living as Married

Home Phone _____ - _____ Work Phone _____ - _____ Cell Phone: _____ - _____

OK to call at work? at home? Restrictions on messages: _____

Other Members of the Household:

Name	Birthdate	Relationship

Employer: _____

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

Referred to this office by: _____

Name of Your Physician: _____ Phone Number: _____

Physician Address: _____

Any Medications Taken at this Time: _____

Allergies and Allergies to Medications: _____

Current Medical Problems or Treatment: _____

If you require Insurance or other third-party billing insurance data and consent forms must be completed.

Signature of Client, Custodial Parent or Guardian: _____ Date: _____

Do not write below this line

Date of First Contact: _____ Billing forms (2) completed? Privacy Notice? Fee Contract?

Fee Set: _____ Treating Professional: Michael P. Dunlap