COUNSELING & CONSULTING, LLC.
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Rev 7-30-19

Client Information

Please Print Clearly:

Date _________________

Who referred you to our office? ____

Client's Name: Last____________________________________First__________________________M.I. _

Client's Date of Birth:_________________________________Sex: M__________F__________

Client's SSN:________-______-_________Check one: Single_______Married______Divorced______Partnered ______

Street Address (No P.O. Boxes) ____

City_______________________________________State_______Zip ____________

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If client is a minor, provide name & relationship of guardian/responsible party:

Guardian's Name: Last________________________________First____________________________M.I.____

Relationship to Client: ____________________________________

Who filled out this form? ____

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Primary Insurance Carrier:__________________________________Policy / Group #: _____________________

Insured's Name:____Insured's Birthdate: __________________

Insured's ID/SSN:_____-_____-______________________Insured's Employer: _______________________

Secondary Insurance Carrier_____________________________Policy / Group #________________________

Insured's Name:_____________________Insured's Birthdate:____

Primary Care Physician (PCP) or Pediatrician's name: ____

PCP Phone number:______________________Fax number: __________________________

PCP Address: ____