KARIN A. CONNELLY, PH.D.
CLIENT INTAKE FORM

First Name: _____ MI _____

Last Name: _____

Address: _____

_____

City: _____State: ____ Zip: _____

Home Phone:_____

Cell Phone: _____

Date of Birth: _____

Gender: _____

Soc. Sec.# _____
(required)

Responsible Party (If other than client)

First Name: _____ MI _____

Last Name: _____

Address: _____

_____

City:_____State: ____ Zip: _____

Home Phone: _____

Cell Phone: _____

Date of Birth: _____

Gender: _____

General Insurance Information

Marital Status
___ Single
___ Married
___ Other

Employment Status
___ Employed
___ Full Time Student
___ Part Time Student

Client Condition Related to:
Employment? ___ Yes ___ No
Auto Accident? ___ Yes ___ No
Other Accident? ___ Yes ___ No

Insurance Company Information

Ins. Co. Name: _____

Address: _____

_____

City: _____ State: ____ Zip: _____

Phone: _____

Fee: $ _____

Copay: $_____

Diagnosis: _____

Policy Holder (if other than client)

First Name: _____

Last Name: _____

Address: _____

_____

City: _____ State: ___ Zip: _____

Gender: _____

Date of Birth: _____

ID Number: _____

Policy Number: _____

Group Number: _____

Authorization Number: _____

From: _____ To: _____

Home Phone: _____

Soc. Sec. # _____

Secondary Insurance: _____
What is your relationship to the insured? Self ___ Spouse ___ Child ___ Other ___
Are you under your employer's health plan? ___ Yes ___ No

Employer's Name: _____

Insurance Plan Name: _____
Is your signature on File? ___ Yes ___ No