

Tamsen Thorpe, Ph.D.
Client Data Form

CLIENT INFORMATION:

Office Use Only: Entered ____/____/____

Name: _____ Home Phone: () _____ - _____
Address: _____ Work Phone: () _____ - _____
City: _____ Zip _____ Cell Phone: () _____ - _____

Emergency Contact Name/Relationship: _____ Emerg Phone: () _____ - _____

Date of Birth: ____/____/____

Soc. Sec. #: _____ - _____ - _____ Sex: Male Female

Marital Status:

- Single
 Married
 Other

Employment Status:

- Employed
 Full Time Student
 Part Time Student

Is Client's Condition Related To:

- Employment? Yes No
Auto Accident? Yes No Which State: _____
Other Accident? Yes No

Referral: Ins. Co. Physician Employer Therapist Friend
Specify name: _____

PAYMENT METHOD: Self Insurance (Complete below)

INSURANCE INFORMATION: (Please have your card ready for photocopy)

Insurance Co. Name: _____

Mental Health Phone: _____

Claims Address: _____

City: _____ Zip _____

Does your insurance plan require pre-authorization/certification? Yes No

If yes, please provide authorization/certification number for initial sessions and quantity of sessions:

Is this policy through a place of employment? Yes No

If yes, name of employer: _____

Policy Holder (If different than patient): Spouse Parent Other _____

Name: _____

Birth Date: ____/____/____

Soc. Sec. #: _____ - _____ - _____

Many insurance plans require that I ask if you would like clinical information sent to your primary care physician;

No, please do not send information. Yes, please send information. (Please fill out and sign release form)