Jennifer Young, LPC

Client Data Form

(Please Print)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
					Single / Mar / Div / Sep / Wid

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
❑ Yes	❑ No			/ /		❑ M	❑ F

Street address:	City:	State/Zip:

Mailing address: (if different)	City:	State/Zip:

Social Security no.:	Home Phone:	Cell Phone:
	( )	( )

Occupation:	Employer:	Employer phone no.:
		( )

How did you hear about our office? (check all that apply)

❑ Primary Care Physician	❑ Insurance Plan	❑ Hospital	❑ Close to home/work	❑ Yellow Pages	❑ Other	

Please list any medications that you are taking:

INSURANCE INFORMATION

Subscriber's name:	Subscriber's social security no:	Subscriber's Birth date:

Address (if different):	Home phone no.:	Cell Phone:
	( )	( )

Is this person a patient here?	❑ Yes	❑ No	Is this patient covered by insurance?	❑ Yes	❑ No

Employer:	Employer address:	Employer phone no.:
		( )

Name of Primary Insurance:	Patient's relationship to subscriber:			
	❑ Self	❑ Spouse	❑ Child	❑ Other

Group no.:	ID no.:	Co-payment: $

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I understand that I am required to give 24 hour notice in case of cancellation(s) or that time will be charged to my account. I, the undersigned certify that I have insurance coverage as noted and assign directly to Jennifer Young, LPC all insurance benefits, if any, otherwise payable to me for the services rendered. **I understand that I am responsible for any and all charges whether or not paid by insurance.** I agree that if this account goes to collection, I am responsible for all legal/collection costs. I hereby authorize Jennifer Young, LPC to release all *Protected Health Information* necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Client Signature:	*Date*
I, hereby give consent for the treatment of my minor child or ward _____ _____by Jennifer Young, LPC Parent/Guardian signature:	*Date*