**Client Information:** **Date:**_____

**Name:**_____ **Sex: (M) (F) Date of Birth:**_____

*Parent Name (If Client is a Child):*_____

**Street Address:** _____

**City, State:** _____ **Zip:** _____

**Marital Status: (M) (S) (D) (W)**

**Phone Numbers: (H)** _____ **(W)** _____
**(Cell)**_____

**E-mail address:**

**Occupation:** _____

**Employer Name:** _____

**Address:** _____

**Employer Telephone Number:**_____

**Primary Contact Person (Emergency):** _____

**Telephone Number of Emergency Contact:**_____

**Relation:** _____

**Referral Source:** _____

**********

**Insurance Information:**

**Type of Insurance:** _____
*Be specific, e.g. not just BC-BS, but plan name/type/state etc.*

**Subscriber Name/Relation:** _____

**Subscriber Address:** _____

**Subscriber Address:** _____ **Phone:** _____

**Sub. DOB:** _____ **Contract Number:** _____

**Group #:** _____ **Other #'s:** _____

**Employer Name/City/Phone :** _____

**Insurance Phone (Provider Call #):** _____

**Other Insurance?** _____

**Name of Person responsible for bill:** _____

I authorize release of all pertinent medical information necessary to process my insurance claims. I assign all health benefits to which I am entitled to Ms. Anna M. Stapleton, M.A., L.L.P. This assignment will remain in effect until discharge from treatment or until revoked by me in writing. A Photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges not covered by insurance. I have read this information and understand it.

**Signature:**_____ **Date:**_____