

Gregory W Gerritsen, PhD: Client Information Sheet

Name of client		
Birthdate	Gender	Social Security #
Mailing Address (Street or PO Box)		
(City, State, Zip Code)		
Telephone Number (home)	(work)	(cell)
Email address:		
Employer (or School)	Position (or Grade/Year)	
Marital Status	If married, spouse's name and years married	
Spouse's: Occupation	Employer	Work Phone #
RESPONSIBLE PARTY Name (if different than above)		
Address (include zip code)		
Telephone Number (home)	(work)	
Relationship to Client	Occupation	
Will you be using insurance? Yes No ♦ If yes, do you want us to bill it? Yes No ♦ If yes, please fill out next section		
INSURANCE COMPANY Name		
Complete Address		
Telephone	Co-Pay Amount (% or flat fee?)	
Employer	Has annual deductible (\$ _____) been met?	
Policy Number	Do you know what limits insurance places on outpatient psychotherapy?	
Group Number		
Insured's Name	Birthdate	Social Security #
Is this visit related to a work injury? (Date)		Or to an auto accident? (Date)
Name and City of Primary Care Physician		
Any current medical conditions, including allergies		
Any Current Medications		
Other Recent Health Care Practitioners		
Previous Mental Health Treatment (include type, dates, and name of treating clinician)		
Emergency Contact (other than spouse)		Relationship
Home phone number		Work phone number
How did you choose this therapist?		

I authorize the release of the above true information and any medical information necessary to process my insurance claims. I further authorize that payment of medical benefits be sent directly to my provider.

Client Signature _____ Date _____

Responsible Party Signature _____ Date _____

Office Use Only:
