CONFIDENTIAL CLIENT INFORMATION

Client Name:_____ Age:_____ Date First Seen:_____

Address:_____ Date of Birth:_____

City_____Zip_____ Home Phone: (_____)_____
Cell Phone: (_____)_____

Family: Names, Ages, Birthdates:_____
_____
_____
_____
_____

If Child: School Name, Grade, Teacher:_____

If Adult: Employer:_____Business Phone: (_____)_____
Employer's Address:_____City_____Zip_____

Marital Status: ( )single ( )married ( )remarried ( )separated ( )divorced ( )widow/er

If Married: Spouse's Name:_____Date of Birth:_____

PRIMARY Insurance Co. Name & **Phone #**: _____
Insurance Co. Address_____
Policy Holder's name:_____
Policy Holder's Date of Birth:_____
Policy Holder's Social Security Number:_____
Policy Holder's Identification Number:_____
Policy Holder's Group Number:_____
Policy Holder's Employer & Business Phone:_____
Authorization Number (if applicable):_____

SECONDARY Insurance Co. Name & **Phone#**:_____
Insurance Co. Address:_____
Policy Holder's Name:_____
Policy Holder's Date of Birth:_____
Policy Holder's Social Security Number:_____
Policy Holder's Identification Number:_____
Policy Holder's Group Number:_____
Policy Holder's Employer & Business Phone:_____
Authorization Number (if applicable):_____

Name and Address of Responsible Party:_____
_____

Responsible Party's Employer & Business Phone:_____
_____

Name of emergency contact:_____ Phone number:_____

Name of Family Physician, Group Name, City:_____
_____

Current Medication of Client:_____

Name of Doctor or Facility Providing Previous Mental Health Services:_____
_____

Where did you hear about this facility? _____

Nature of Problem:_____
_____
_____
_____
_____

Please Note Office Cancellation Policy:

Each appointment is reserved for only one person or family.
Reserved time must be canceled at least 24 hours ahead to avoid full charge.

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I request that payment of authorized insurance benefits be made on my behalf to:

MICHAEL J. FERRARESE, PH.D., L.P.
SOUTH SUBURBAN PSYCHOLOGICAL AND COUNSELING SERVICES

For any services furnished to me by Dr. Ferrarese. I authorize the release of any medical or other information necessary to process this claim.

I permit a copy of this authorization to be used in place of the original.

_____ _____
Patient Signature (or Parent or Guardian) Date