MICHAEL LIPSTEIN, MA, LMFT, PS
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CLIENT INFORMATION

FIRST APPOINTMENT DATE: ____________________________

CLIENT NAME: ____ DATE OF BIRTH: ____________________

STREET ADDRESS: ___________________________________SOCIAL SECURITY NO:____________________

MAILING ADDRESS IF DIFFERENT__________________________ DRIVERS LICENSE #_________________

CITY ______________________________________STATE____________ ZIP_________________________

▯ HOME PHONE__________________▯ CELL PHONE______________▯ BUSINESS PHONE_____________

PLEASE CHECK IF OK TO LEAVE MESSAGES ON ABOVE LISTED PHONE NUMBERS

GENDER: ▯Male ▯ Female MARITAL STATUS: ▯S ▯M ▯D ▯SEP ▯ WID

EMPLOYER: _____________________________OCCUPATION: ______________________________ ▯ FT ▯ PT

ADDITIONAL PARTICIPANT____________________________________DATE OF BIRTH_______________

STREET ADDRESS________________________________SOCIAL SECURITY NO:_______________________

MAILING ADDRESS IF DIFFERENT_______________________________ DRIVERS LICENSE#_____________

CITY____STATE___________ZIP____________________________

▯HOME PHONE ________________▯CELL PHONE__________________▯BUSINESS PHONE_____________

PLEASE CHECK IF OK TO LEAVE MESSAGES ON ABOVE LISTED PHONE NUMBERS

GENDER: ▯MALE ▯FEMALE MARITAL STATUS: ▯ S ▯M ▯D ▯SEP ▯WID

EMPLOYER______________________________OCCUPATION______________________________ ▯ FT ▯ PT

PERSON RESPONSIBLE FOR THIS ACCOUNT

If same as client, check here ▯

NAME: ____ DATE OF BIRTH: _________________________

ADDRESS: ____PHONE: __________________________

CITY:____STATE_______________ZIP_______________

EMPLOYER: _______________________ OCCUPATION_________________BUSINESS PHONE: ___________

SOCIAL SECURITY #: ______________________________________CHECK ONE: Full-Time ___ Part-Time_____

INSURANCE INFORMATION

INSURANCE COMPANY: ____

POLICY OR MEMBER #____ GROUP # ______________________

INSURED'S NAME: _______________________________________ DATE OF BIRTH: _____________________

AUTHORIZATION RECEIVED? ▯Y▯N AUTH #____

DO YOU HAVE A SECONDARY INSURANCE? IF SO, NAME OF COMPANY______________________________

INSURED'S NAME_______________________________________ POLICY OR MEMBER #_________________

PRIMARY CARE PHYSICIAN_______________________________OTHER PROVIDER_____________________

BY WHOM WERE YOU REFERRED TO US?____