Dragonfly Counseling & Consultation
Susan G. White, LMFT

CLIENT INFORMATION FORM

DATE_____

CLIENT NAME_____DATE OF BIRTH_____

ADDITIONAL FAMILY MEMBERS

_____DATE OF BIRTH_____

_____DATE OF BIRTH_____

_____DATE OF BIRTH_____

STREET_____CITY_____ST_____ZIP_____

MARITAL/RELATIONSHIP STATUS_____SEX/GENDER_____

HOME PHONE_____WORK/CELL PHONE_____

EMAIL_____

REFERRED BY_____

INSURANCE INFORMATION

NAME OF INSURED_____ DATE OF BIRTH_____

MARITAL/RELATIONSHIP STATUS_____SEX/GENDER_____

INSURANCE CARRIER_____PHONE_____

ID#_____

RELEASE OF INFORMATION

I authorize the release of any medical or other information necessary to process this claim.

Signature _____Date_____

I authorize payment of medical benefits directly to the provider.

Signature _____Date_____