Leslie G. Cohn, Ph.D.
Clinical Psychologist

CLIENT INFORMATION

Full Name ____________________ Date of Birth ______________ Age ________ Marital Status ______________

Address ____

Business Address ____

Pronouns ____________________ Occupation ____________________ Employer ____________________

Telephone ____________________ ____________________ ____________________
(home) (business) (message/pager/cell)

At which # do you prefer to be called? ______________ Okay to leave a message at this number? ______________

If you were referred, who referred you? ____

Briefly describe your reason(s) for seeking help ____

____

____

Current medications (if any) ____

____

Primary Care Physician ______________________________ Date of last exam ____________________

Physical health problems/concerns ____

Emergency Contact ______________________________ Relationship ____________________

Emergency Contact's Phone Number ____

Name of Insurance Company ____

Does your healthcare plan require preauthorization for mental health benefits? ____________________

Policy ID number ______________________________ Group ID number ____________________

Subscriber Name ______________________________ Date of birth ____________________

Subscriber's Employer ____

Subscriber's Address ____

I authorize the release of any medical or other information necessary to process health insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment. (To insure confidentiality, if your insurance company requests information not typically used to process claims, I will obtain your consent prior to releasing this information.)

Signed ____

Date ____

updated 6/18/20