Dr. Office/Clinic Name:				Location (city,state):	
Primary Care Provider (Physician):				Phone :	Fax:
CLIENT INFORMATION					
Last name: First: Middle:				Medical Diagnosis: Yes ☐ No ☐	If Yes please list Medical Diagnosis:
Sex: ☐M ☐F	Birth date:	Age:	Caregivers (If applicable):		
Street Address:			City:		Zip Code:
Cell Phone:	Home Phone:		Email:		
Occupation:	Employer:				Employer phone no.:

INSURANCE INFORMATION			
Policy Holder:	Birth date:	Address (if different):	Home phone :
Occupation:	Employer:	Employer address:	Employer phone:
Are you covered by insurance?	❑ Yes	❑ No	
Primary Insurance Carrier:	Birth date:	Group no.:	Policy no.:
Client's relationship to subscriber:	❑ Self	❑ Child	❑ Other
Name of secondary insurance (if applicable):		Group no.:	Policy no.:
Client's relationship to subscriber:	❑ Self	❑ Child	❑ Other
Referred to clinic by	Please Select		Other:
Other services you receive:			

IN CASE OF EMERGENCY		
Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Therapy Junction, INC. I understand that I am financially responsible for any balance. I also authorize Therapy Junction or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*