DEMOGRAPHICS / INSURANCE Today's Date: _____

CLIENT NAME: _____ Age: _____ DOB: _____

Address, City, State & Zip Code: _____

_____

Cell# _____ Home# _____

Work# _____

REFERRED BY: _____ Phone# _____

EMERGENCY CONTACT: _____ Relationship: _____

Cell# _____ Home# _____Work# _____

PRIMARY INSURANCE COMPANY: _____

Member ID# _____ Group# _____

Phone# and Department: _____

Subscriber's Name: _____ DOB:_____

Employer: _____ Relationship to client, if not self: _____

Subscriber's address (street,city,state,zip) if different from client: _____

_____

SECONDARY INSURANCE COMPANY: _____

Member ID# _____ Group# _____

Phone# and Department: _____

Subscriber's Name: _____ DOB: _____

Employer: _____ Relationship to client, if not self: _____

Subscriber's address (street,city,state,zip) if different from client: _____

_____

The above information is accurate. If there are any disputes with my insurance company, I understand that I am fully responsible for payment of services, rendered to John Geremia, LCSW-C. I authorize the release of any necessary information for any related claims to my insurance company. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time, in writing.

_____ _____

(ADULT Signature is requested) ***(Date is requested)***

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