DEBORA ROSS, LMFT
1234 Pearl Street, Suite 3, Eugene, Oregon 97401
INTAKE INFORMATION

CLIENT IDENTIFYING INFORMATION

Today's Date_____

Legal Name _____Preferred Name_____

Date of Birth: _____ Age: _____Relationship Status:_____

Partner's Name (if being seen as a couple): _____

Address: _____City, State, Zip: _____

Home phone: _____(Work) _____(Cell)_____

Partner's phone: _____

Social Security (ID) Number: Self: _____ Partner (optional): _____

_____

May we leave messages for you at home? ☐ Yes☐ No/ May we leave messages for you at work?☐ Yes ☐ No

Gender as Specified on Insurance: ☐ Male ☐ Female Gender Self-Identification, if different: ☐ Male ☐ Female ☐ Other

Others Living in Home (name, birth date, relationship to client): _____

_____

Occupation: Self: _____Partner: _____

Client's Employer: _____

Emergency Contact: _____Phone: _____

Referred by: _____

INSURANCE INFORMATION

Name of Insured: _____Insured Date of Birth:_____

Address of Insured:_____City, State Zip: _____

Relationship of Client to Insured: _____Employer of Insured:_____

Insurance Company:_____Phone: _____

Insurance Company Address: _____City, State Zip:_____

Insurance Identification Number: _____Group Number: _____

Secondary insurance: _____Phone: _____

Name of Secondary Insured: _____Insured Date of Birth:_____

Secondary Company Address: _____City, State Zip:_____

Secondary Identification Number: _____Group Number: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

_____

Signature Date

FOR PROVIDER USE ONLY
DSM-5: DIAGNOSIS: ICD-10 DIAGNOSIS: