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Client Information

Please complete all information and sign below. Thank you.

Demographic Information	
Date:	Highest Level of Education:
Name:	Occupation:
Date of Birth:	Employer:
Address:	Work Address:
Home Phone:	Gender:
Work Phone:	Marital Status:
Cell Phone:	Ethnic Background:
E-mail Address:	
Driver's License Number:	Who referred you to my office?
Social Security Number:	Permission to contact them to thank them for the referral?
Emergency Contact #1 Name:	Emergency Contact #2 Name:
Emergency Contact #1 Phone:	Emergency Contact #2 Phone:
Emergency Contact #1 Relationship:	Emergency Contact #2 Relationship:

Insurance Information	
Insurance Company:	Primary Insured's Name:
Insurance Address:	Primary Insured's Date of Birth:
Insurance Phone:	Primary Insured's Social Security Number:
Group Number:	
Policy Number:	
Copay Amount:	

I authorize my insurance company to make payments directly to Alexandra M. Chiara, Ph.D. for professional services rendered. I also authorize the release of any information necessary to obtain approval for treatment and to process insurance claims for such services. I understand that I am responsible for all charges regardless of insurance coverage.

_____ _____

Signature of Client, Parent or Legal Guardian **Date**