

Date _____

Client Information Update

Please fill in all applicable areas; print clearly and carefully. Incorrect or illegible information causes significant delays. Bring your insurance card or provide a copy of both sides of your card. Thank you.

Client's Name _____

Address _____

City/State/Zip _____

Phone: Home _____ Cell _____ Work _____

Email _____

Primary Insurance

Name of Insured _____ Insured DOB _____

Relationship to Client _____ Employer _____

Insurance Company _____

Insurance Address _____

Insurance Phone _____

Group # _____ ID # _____

Check if this is an EAP Authorization # _____

Secondary Insurance

Name of Insured _____ Insured DOB _____

Relationship to Client _____ Employer _____

Insurance Company _____

Insurance Address _____

Insurance Phone _____

Group # _____ ID # _____