CLIENT IDENTIFICATION FORM — LEHIGH PSYCHOLOGICAL SERVICES

I. Client's Name _____ Is client a minor? yes___ no____

Address _____

City _____ State _____ Zip _____

Employer _____ Employer Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ Social Security Number_____
(Month/Day/Year)

II. Spouse's Name [or Parent/Guardian, if minor] _____

Birthdate _____ Social Security Number _____
(Month/Day/Year)

Address (if different) _____

City _____ State _____ Zip _____

Employer _____ Employer Address _____

Home Phone _____ Work Phone _____

III. Primary Care Physician _____ Address _____

Psychiatrist (if applicable) _____ Address _____

Please fill out Section IV you haven't already provided our office staff with this information:

IV. Name on Insurance Card _____ Check Here if Solely Self-Pay _____

Insurance Company Name _____ Ins. Co. Phone #/Approvals _____

Identification/Agreement/Policy # _____ Group # _____

Name on Secondary Insurance Card _____

Identification/Agreement/Policy # _____ Group # _____

V. ***How did you hear about Lehigh Psychological Services? (please check all that apply)***

__ Physician Referral: Dr. _____
__ Client Referral
__ Insurance Company Directory
__ Yellow Pages: under Counselors___ under Psychologists ___
__ Brochure
__ Newspaper Article
__ Website
__ Other _____