New Client Intake Form
Dr. Linda Klaitz, Medical Psychologist

Name: ______________________ Today's Date ______________________

Address: ____

Street City State Zip Code

Home Phone: __________________ Work Phone: ____________________

Cell Phone__________________________ E-Mail Address__________________

Employer and Occupation: ____

Age: ______ Date of Birth: ____________ Marital Status: __________

Social Security Number ____________________

Name of Spouse (if applicable): ____________________

Age of spouse: ________ Date of Birth: ____________

Employer and Occupation: ____

Work Phone: ________________ Email____________________

Children (if applicable): List name and age –

__________________________ __________________________

__________________________ __________________________

INSURANCE INFORMATION

_______Check here if we will be filing insurance for you. If you check this box, please present your insurance card to Dr. Klaitz so she may make a copy of it. Also, in order to receive payment, we must have the following information:

Name of Insured: ________________________

Insured Date of Birth: ____________________

Patient Social Security Number__________________

Relationship to client: ____________________

I authorize the release of any information to obtain assignment of health care benefits for service.

Signature of Client: ______________________________________

I authorize payment of medical benefits to my Doctor for services rendered.

Signature of Client: ______________________________________

Name and address of person providing payment if different than above:

Name: ________________________