

Dr. Bergin Family Counseling Services



NEW CLIENT INFORMATION

Patient Name _____

_____ Date of Birth

Guardian (if applicable) _____

_____ Date of Birth

Address _____

Street

City

Zip Code

Home Phone () _____ Mobile Phone () _____

Work Phone () _____ E-mail address _____

Social Security # _____ - _____ - _____ Marital Status: S M D

Employer _____

Name

Address

Emergency Contact

Name _____ Relationship _____

Home Phone () _____ Mobile Phone () _____

Work Phone () _____

Insurance Information

Ins. Company _____ Provider Phone () _____

ID# _____ Group/Policy # _____ Account # _____

HMO PPO EAP Authorization # _____ # of Sessions _____

Co-pay \$ _____ Deductible \$ _____ Sessions p/year _____

Policy Holder _____ Policy Holder DOB _____

Employer _____ Policy Holder SS# _____