



**Client Information Form**  
**(Couples: each partner should fill out their own individual form)**

Date: \_\_\_\_\_

Client Name \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt or Box #: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone Number (\_\_\_\_) \_\_\_\_\_ Cell Phone Number (\_\_\_\_) \_\_\_\_\_

Work Phone Number (\_\_\_\_) \_\_\_\_\_ Date Of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

eMail Address: \_\_\_\_\_

(Note: I will only send exchange emails through Protected Trust, a HIPAA-compliant service.)

Phone(s) at which Dr. Bernstein can leave messages: \_\_\_\_\_

How I learned about Dr. Bernstein's practice: \_\_\_\_\_

Why I chose to make an Appointment with Dr. Bernstein: \_\_\_\_\_

**FAMILY/HOME INFORMATION (if applicable)**

<u>Children</u>	<u>Age</u>	<u>Living at Home?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**INSURANCE INFORMATION. Fill out below AND Bring card to first appointment**

If you will need a bill to submit to your insurance company for reimbursement, please provide the following information:

Insured's Name: \_\_\_\_\_ Policy or Group #: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Insured's Phone Number: \_\_\_\_\_ Insured's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Client's ID #: \_\_\_\_\_