New Client Data

The SUMMIT Therapy Center
4419 Cleveland Rd, Wooster, OH 44691
Ph: (330)345-8450 Fax: (330)345-5899

Please print clearly, fill this out to the best of your ability and bring it to our office. Thank you!

Date: _____

Patient

Name: _____ Home Address: _____

City: _____ County: _____ State: _____ Zip: _____ Sex(M or F): _____

Personal Phone: _____ Work Phone: _____ Email: _____

Birth Date: _____ SSN: _____

Employer: _____ Business Address: _____

Occupation: _____ Education Completed: _____

Family Physician: _____

Have you ever seen a mental health professional before? ___ When? _____

Please list current allergies, medications/dosages, and conditions being treated: _____

_____

Primary Insurance (Y or N): ___ *If Yes, please complete insurance information below for the Subscriber.*

Name: _____ Subscriber's Address: _____

Employer: _____ Subscriber's Address: _____

Subscriber's Birth Date: _____ Subscriber's SSN: _____

Insurance Company: _____ ID: _____ Group #: _____

Secondary Insurance (Y or N): ___ *If Yes, please complete insurance information below for the Subscriber.*

Name: _____ Subscriber's Address: _____

Employer: _____ Subscriber's Address: _____

Subscriber's Birth Date: _____ Subscriber's SSN: _____

Insurance Company: _____ ID: _____ Group #: _____

Responsibility:

If someone else is responsible for this account, please complete the following information. Account #: _____

Name: _____ Home Address: _____

City: _____ County: _____ State: _____ Zip: _____ Sex(M or F): _____

Personal Phone: _____ Work Phone: _____ Email: _____

Relationship to Patient: _____

Emergency contact: _____ Phone: _____

Who may we thank for referring you to us? _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for payment of any professional services rendered. I hereby authorize The SUMMIT Therapy Center to disclose any protected health information of named individuals listed above to receive payment of medical benefits for service rendered by The SUMMIT Therapy Center staff. I certify that the above information is true and correct to the best of my knowledge. I will notify The SUMMIT Therapy Center of any changes in my health status or in the above information.

Patient/Guardian: _____ Therapist: _____ Date: _____