Today's Date
_____

Clinician
_____

Clarity Counseling Associates
1D Commons Drive, Unit 23
Londonderry, NH 03053
603-425-7600

Client Name: _____ Client DOB: _____/_____/___

Birth Sex: ◯ Male ◯ Female
Marital Status: ◯ Married ◯ Single ◯ Other
Employment Status: ◯ Employed ◯ FT-Student ◯ PT-Student ◯ Unemployed/Other

Gender Identity: ◯ Transgender Male/FTM ◯ Transgender Female/MTF ◯ Choose not to disclose

Parent/Guardian Name if a minor: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ OK to leave messages? YES NO

Cell Phone: _____ OK to leave messages or text? YES NO

Cell Phone: _____ OK to leave messages or text? YES NO

Email: _____

Primary Insurance Information: Insurance Name: _____

Client's Insurance ID Number: _____ Subscriber's Insurance ID Number: _____

Subscriber's Full Name _____ Subscriber's DOB: _____

Subscriber's Relationship to Client _____

Subscriber's Policy/Group # : _____

Subscriber's Street Address (if different from above) _____

Subscriber's City/State/Zip: _____

If you are divorced and/or remarried with dependents, please complete the following:

Dependents	Person with Physical Custody	Relationship	Person Responsible for Dependent Health care Expenses per divorce decree

If you or your family members are covered under any other medical plan in addition to the coverage listed above (i.e. Medicaid), please complete the following section. This does not include the employee's current insurance plan.

Health Plan Name	Name of Person Covered	Policy Number	Effective Date

Patient Signature or (Legal Guardian if under 18 years) **Date:**

_____