Miriam Vinton LPC
(303) 870-6845

Client Information (Confidential)

Client's Name _____

Address _____

City _____ State_____ Zip _____

Home Phone _____ Work Phone _____

Email _____

Date of Birth _____

Employment Status _____ Occupation _____ Employer _____

Emergency Contact _____ Phone _____ Relationship _____

Primary Care Physician _____ Phone _____

Referred By _____

Responsible Party

Do you have Major Medical Insurance? _____ If not payment is expected in full today.

Insurance Co. Name _____

Insurance ID # _____ Group # _____

Name of Policy Holder _____ Phone _____

Address _____ Birthdate _____

Employer _____ Relationship to Client _____

Do you have Secondary Insurance ? _____

Insurance Company Name _____ Relationship to Client _____

Insurance ID # _____ Group # _____

Name of Policyholder _____ Phone _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Signature
I acknowledge the above information is true.

Signature _____

Printed Name _____ **Date** _____