Date: ______________________

FEATHERGILL & ASSOCIATES THERAPIST: _________________
New Client Information

Last Name:____ First Name: _______________________________________

Middle Initial: ________ Nickname: ______________________________ Date of Birth: __________________________

Gender: ____ Female ____ Male Marital Status: ____ Married ____ Single ____ Other______

Employment Status: ____Employed ____ Full Time Student ____Part Time Student ____ Other

Referred by: ____

For Therapist Use:
Diagnoses Codes: 1. 2. 3.

Allergies: ____

Condition Related to Employment? ____ Yes ____ No

Condition Related to an Auto Accident? ____ Yes ____ No State Accident Occurred in? _______

Condition Related to any other Accident? ____ Yes ____ No

Email Address: ____

Address Line 1: ____

Address Line 2: (optional) ____

City ____________________________ State ______________________ Zip Code: ___________________

Home Phone #: ___________________________________ Work Phone #: _________________________

Cell Phone #: ____________________________________ Preferred Contact #: Home Work Cell

Emergency Contact Name: ___________________________________ Phone: ___________________

Other Responsible Party (Who pays bill?) ____

Responsible Party Address: ____

City:______________________________________ State:________________ Zip Code: ______________________

Would you like an appointment reminder? ____ Yes ____ No ____ Phone ____ Email ____ Text

Client Signature: ____ Date: __________________________

INSURANCE INFORMATION: Please complete this section if using insurance. Present card to therapist.

Primary Insurance Company: ____

Insurance ID #: ______________________________Group #: ______________________

Effective Date: ____________ Patient's Relationship to Insured: _____ Self _____ Spouse ___ Child

Insured's Name: (Last, First MI) ____

Insured's Street Address: ____

City: ______________________________ State: __________ Zip Code: _______________

Insured's Phone Number: _____________________

Insured's Date of Birth: _____________ Insured's Gender: ___ Female ___ Male

Insured's Employer: ____

For Office Use Only

Deductible: $ ______________ Amount Met: $ ____________

Pays At: ________________% Usual Fee or Copay: $ __________

Visit Limit/Year: ___________ Precert Required? ____ Yes ____ No

Precertification by Whom: ____

Precertification Phone: ______________ Auth # ___________________________

Secondary Insurance Company: ____

Secondary Insurance Address:____

Secondary Insurance Phone #: _______________________

Other Insured's Name (Last, First, MI): ____

Other Insured's Address: ____

Other Insured's Gender: ____ Female ____ Male Other Insured's Date of Birth: _______________

Other Insured's Policy ID #: ________________________ Group #: __________________

Other Insured's Employer: ____