3-C Family Services, P.A.

Complete psychological care for children and families

CLIENT INFORMATION FORM

All fields are required to be completed on this form

Date: _____/_____/_____

Client's Name: _____
First Middle Last

Address: _____
Street/ Apt. City State Zip Code

Phone # (_____)_____ Alternate Phone # (_____)_____

Occupation & Place of Work: _____

Social Security #: _____ - _____- _____ Date of Birth: _____/_____/_____
MM DD YYYY

Primary Physician & Phone#: _____

_____
Client's Signature *(required for all clients 18 years old or older)*

Parent(s) or legal guardian(s) financially responsible for the minor client listed on this form above are required to complete the following section.

☐ Parent or ☐ Legal Guardian's Name: _____
First Middle Last

Address: _____
Street/ Apt. City State Zip Code

Phone # (_____)_____ Alternate Phone # (_____)_____

Occupation & Place of Work: _____

Social Security #: _____ - _____- _____ Date of Birth: _____/_____/_____
MM DD YYYY

_____
Parent's or Legal Guardian's Signature *(required for all clients 17 years old or younger)*

Per the Health Insurance Portability and Accountability Act (HIPAA) this information is strictly confidential.

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