

JUSTINE STOHL, LICSW

45 Lyman St #19
Westbrough, MA 01581
justinestohl@gmail.com
978-938-4488
Fax: 508-366-0335

Client Information Sheet

NAME_____ DOB_____

ADDRESS_____

TOWN/STATE/ZIP_____

HOME PHONE_____ WORK PHONE_____

CELL PHONE_____

EMAIL_____

EMPLOYER/SCHOOL_____ FT/PT

FIRST LANGUAGE_____ REFERRED BY_____

RELATIONSHIP TO SUBSCRIBER_____

NAME OF INSURANCE COMPANY_____

INSURANCE COMPANY ADDRESS

ID NUMBER _____ GROUP NUMBER _____

INS PHONE NUMBER _____ OTHER INFO _____

SECONDARY INSURANCE _____

ID NUMBER OF SECOND INSURANCE _____

Please complete if above name is different from subscriber

SUBSCRIBER NAME _____ DOB _____

ADDRESS _____ PHONE _____

EMPLOYER _____

PLEASE GIVE BRIEF REASON FOR SEEKING SERVICES _____

PAST HOSPITALIZATIONS FOR EMOTIONAL/MENTAL HEALTH? YES NO

IF YES, PLEASE BRIEFLY EXPLAIN

To be completed by clinician

DIAGNOSIS _____ DATE OF FIRST VISIT _____

DATE OF ELIGIBILITY _____ COPAY _____

DEDUCTIBLE _____ YEARLY MAX _____ PARTY? YES/NO

AUTHORIZATION REQUIRED? YES/NO IF YES, BY: PHONE/ONLINE/FORM

AUTH# _____ #VISITS _____ DATES _____