MADISON T. WEST, MFT

1690 Stone Village Ln NW, Suite 622, Kennesaw, GA (678) 740-3578

CLIENT DEMOGRAPHIC FORM

Today's Date:

CLIENT INFORMATION

Client's last name	First	Middle	Date of Birth	Age	Gender
					☐ M ☐ F

Marital Status	Home Phone	Cell Phone
☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Separated ☐ Widowed		

Street address	City	State	ZIP Code

Person responsible for bill (if a minor):		
Social Security	Employer	Employer phone

Referred By:	☐ PCP		☐ Family	☐ Friend	☐ Insurance Plan	☐Other:	

Current Medications:	

INSURANCE INFORMATION
(PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD FRONT AND BACK)

Name of Primary Insurance	Primary Insurance Phone

Subscriber's name	Subscriber's SS#	Birth date	Subscriber ID#	Group#	Co-payment
					$

Client's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

Name of Secondary Insurance (if applicable)	Secondary Insurance Phone

Subscriber's name	Subscriber's SS#	Birth date	Subscriber ID#	Group#	Co-payment
					$

Client's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to Client	Home phone	Work phone

I authorize the release of any medical/mental health information necessary to process my insurance claims. I authorize payment of health benefits to Madison T. West, MFT for services rendered. I have read or completed this form fully and completely, and certify I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand I am responsible for payment of any deductible and co-payment/coinsurance as determined by my insurance carrier. If I need to cancel or change an appointment, I will provide at least 36-hour notice prior to the appointment in order to avoid a charge for the missed appointment or late cancellation. *{Please note that insurance companies will not cover missed or no-show appointments}.* **I will be fully responsible for this charge if I do not give the proper 36-hour notification.**

X	
Client/Guardian signature	*Date*

Internal Use Only

DX Codes:		*CPT Codes:*		*Place of Service:*	☐ *Home* ☐ *Office*