



The Clinic @ The Montgomery

Individual & Family Therapy, Parenting Coordination, & Dispute Resolution

Dr. Jonathan Eric Carroll, KLPC, NCCE, NCPC, Fellow (AAPC)

CLINICAL DIRECTOR

CLIENT INTAKE FORM

General Information					
Patient Registration Form					
Today's Date:					
Patient Information					
Last Name:	First:	Middle:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital Status (Circle One)
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid
Street Address:		City:	State:	Zip Code:	
Home Phone no.:	Cell/Other Contact no.:	Social Security no.:	Birth Date:	Sex:	
				<input type="checkbox"/> M <input type="checkbox"/> F	
Employer:		Occupation:	Work Phone no.:		
Street Address:		City:	State:	Zip Code:	
Referring Doctor (if required by insurance):					
Notify Primary Care Physician?		Name of Primary Care Physician		Contact no.:	
<input type="checkbox"/> Yes <input type="checkbox"/> No				()	
In Case of Emergency					
Emergency Contact Name:		Home Phone no.:	Cell Phone no.:		
Insurance Information*					
Insured's Last Name (If Different):	First:	Middle:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital Status (Circle One)
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid
Home Phone no.:	Cell/Other Contact no.:	Social Security no.:	Birth Date:	Sex:	
				<input type="checkbox"/> M <input type="checkbox"/> F	
Insurance Company:		Insurance Billing Address:		Insurance Phone no.:	

Policy no.:	Group no.:	Relationship to Insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent
Secondary Insurance Information (If Applicable)					
Insurance Company:	Insurance Billing Address:		Insurance Phone no.:		
Policy no.:	Group no.:	Relationship to Insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize, those acting on the practice's behalf, and my insurance company to release any information required to process my claims. Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.</p>					

Patient/Guardian Signature			Date		
<p>*Note: The Clinic @ The Montgomery doesn't file insurance claims on behalf of clients. However, clients are wellcome to self-file. Dr. Carroll will provide all the necessary information at your request.</p>					

Please describe below your reason(s) for seeking therapy.
(Be as thorough and specific as you can in the space provided.)