



For Office Use Only

Therapist: _____
DX Code: _____
Ref. By: _____
First DOS: _____ / _____ /20 _____
Auth. #: _____
Where did you find out about us? (Flynn Ad? Front Porch? Web?) _____ _____

Client Name \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Street Address \_\_\_\_\_ City / State \_\_\_\_\_, VT \_\_\_\_\_ Zip code \_\_\_\_\_ 054 \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home phone Work phone Cell / Other

**PRIMARY INSURANCE COMPANY & PHONE #:** \_\_\_\_\_

Certificate # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name (if different from client) \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Street Address \_\_\_\_\_ City / State \_\_\_\_\_ Zip code \_\_\_\_\_

Place of employment: \_\_\_\_\_

Relationship to client:  Self  Spouse  Child  Other \_\_\_\_\_

**SECONDARY INSURANCE COMPANY & PHONE #:** \_\_\_\_\_

Certificate # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name (if different from client) \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Street Address \_\_\_\_\_ City / State \_\_\_\_\_ Zip code \_\_\_\_\_

Place of employment: \_\_\_\_\_

Relationship to client:  Self  Spouse  Child  Other \_\_\_\_\_

**RESPONSIBLE PARTY FOR PAYMENTS NOT COVERED BY INSURANCE:**

Name: \_\_\_\_\_

Street Address (if different from client) \_\_\_\_\_ City / State \_\_\_\_\_ Zip code \_\_\_\_\_



\_\_\_\_\_  
Signature of responsible party