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#: _____

**Please provide your email address if you are interested in receiving our clinic newsletters & updates**

Email: _____

_____
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.*