Gerald W. Greenfield, Ph.D.

Licensed Psychologist

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Individual Psychotherapy
Marital and Couples Therapy
Evaluations

Client Information

Last Name_____ **First Name**_____ **Initial**____

Date of Birth_____ **Age**____ **Sex**: F__ M__ **Marital Status**: S__ M__ Sep.__ Div.__ Other__

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone_____ **Work Phone**_____ **Cell/Pager**_____

Occupation_____ **Employer**_____ **Student?** Yes___ No___

If you may or will use insurance, please fill in the following section about your primary insurance:

Insurance Company_____ **Phone (800#, if available)**____-____-_____

Your Social Security Number_____ **Subscriber No.**_____ **Group No.**_____

Address for Claims_____

If you are **not** the insurance policy holder, please provide the following information ***(italicized items)*** about the ***policy holder*** (e.g., parent, spouse):

Full Name_____ ***Date of Birth***_____ ***Relationship to you***_____

Address_____ ***City***_____ ***State***_____ ***Zip***_____

Home phone (w/ area code) _____-_____-_____ ***Work phone(w/ area code)*** _____-____-_____

Social Security Number_____-____-_____ ***Employer***_____

If you also have secondary insurance, please fill in the following section about your secondary insurance:

Full Name of Secondary Policy Holder_____

Insurance Company_____ **Phone (800#, if available)**____-____-_____

Subscriber Number_____ **Group Number**_____

Address for Claims_____

Is the condition for which you are seeking treatment related to:

Employment?_____ Auto Accident?_____ Other Accident?_____