

Dyer P. Bilgrave, PhD
Licensed Psychologist

Client Information Form

Date: _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Date of Birth: _____ Age: _____ Gender: __ M __ F

Email: _____

Insurance Information

Fill out only if you are using insurance.

Insurance Co: _____ Subscriber's Name: _____

Insurance ID #: _____ Group #: _____

Insurance company telephone number for mental health (on back of card) _____

Emergency Contact Information

In case of emergency, whom should I contact? _____

Relationship to you: _____

Phone number home: _____

Phone number work: _____

Phone number cell: _____