
885 W. Baxter Dr. South Jordan, UT 84095

## Client/Consumer Information

Client full name: _____ Date: _____
Date of birth: _____ Sex: M F Marital status: _____
Client street address: _____ City: _____
Zip: _____ Best contact number: _____
Home phone: _____ Cell phone: _____
Email address: _____

## Responsible Party Information

Responsible party: _____ Relationship to client: _____
Date of birth: _____ Sex: M F
Street address (if different from client): _____ City: _____
State: _____ Zip: _____ Best contact number: _____
Home phone: _____ Work phone: _____ Cell phone: _____
Emergency Contact (not living with you) _____ phone: _____

## Insurance Information

Primary Insurance: _____ Policy holder name: _____
Relationship to client: _____ Policy holder date of birth: _____
Employer: _____ Employer phone: _____
Group # if available: _____ Identification #: _____

Would you like us to bill a secondary insurance? Y N If yes, please provide the same insurance and billing information requested above for the secondary policy:

_____
_____
_____
_____

**Consent for Treatment:** I attest that the above information is true and accurate. I consent for this information to be used for billing purposes.

_____ _____
Signature of Responsible Party Date