MOSAIC THERAPY
Phone: (877) 691-7994 Email: info@mosaictherapy.org

CLIENT DEMOGRAPHIC FORM

Last Name: _____ First Name:_____ Birthdate: _____

Parent/Guardian: _____

Mailing Address: _____

City: _____ State: _____ Zip:_____

Home Phone_____Work Phone_____

Cell/Other Phone: _____ Email: _____

Marital Status: M S W D Gender M F

IN ORDER TO FOLLOW UP DURING AND AFTER SERVICES, PLEASE CIRCLE Y(YES) OR N(NO):

HOME:	WORK:	CELL/OTHER:
Permission to call you: Y / N	Permission to call you: Y / N	Permission to call you: Y / N
To leave message: Y / N	To leave message: Y / N	To leave message: Y / N
		or Text: Y / N

MAIL: Permission to use Mailing Address: Y / N

Special Instructions:_____

Insurance Company: _____ Co-pay Amount: $_____

Insurance ID #: _____ Insurance Group #:_____

Insurance Mailing Address: _____

City: _____ State: _____ Zip:_____

Insurance Phone #:_____

Does your insurance require pre-authorization? Y / N

Authorization # if required: _____

Name of Benefit Holder: _____ Birth Date:_____

Benefit Holder's Relationship to Client: _____

Benefit Holder's Employer: _____

Emergency Contact

In the event of an emergency, Mosaic Therapy has permission to contact the following:

Last Name: _____ First Name: _____

Relationship to Client: _____

Mailing Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____Work Phone: _____

Cell/Other Phone: _____ Email: _____