MARCIA HOFFMANN, L.C.S.W.
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NEW CLIENT INFORMATION

PATIENT'S NAME: _____ **TODAY'S DATE:** _____

DATE OF BIRTH: _____ **AGE:**_____ **SEX:**_____ **MARITAL STATUS:**_____

HOME ADDRESS:_____ **CITY / SATE / ZIP:** _____

EMAIL: _____ **BUSINESS PHONE:** _____

HOME PHONE:_____ **PATIENT SOCIAL SECURITY:** _____

CELL PHONE:_____ **STUDENT STATUS:** ☐ **NONE** ☐ **FULL TIME** ☐ **PART TIME**

TEXTING?: ☐ **YES** ☐ **NO** **REFERRED BY:**_____

NOTE: The office line 949 - 836 - 1866 is able to receive and send text messages. Many clients choose to communicate that way. If you DO NOT want to communicate via text for confidentiality reasons, please make sure that "NO" is checked above.

Please be aware that text messages cannot be accessed remotely and may not get to me immediately.

What Is the Relationship of Person Filling out this Form to Patient: _____

Person Financially Responsible for Payment of Services and /or Subscriber of the Primary Insurance Plan:

Subscriber:_____ Social Security Number:_____

Home Address:_____ City/State/Zip:_____

Home Phone: _____ Business Phone: _____

Occupation/Title:_____ Employed By:_____

Subscriber Date of Birth:_____ Policy ID Number :_____

Insurance Company:_____ Phone Number:_____

Insurance Address:_____ FAX Number_____

City/State/Zip:_____ Plan Name/ Group Number:_____

IPA/HMO Name:_____

Subscriber Relationship to Patient: ☐Self ☐Parent ☐Spouse ☐Dependent

Employment: ☐Full Time ☐Part Time ☐Not Employed ☐Unknown ☐Retired

- - - - - - - - - - - - Office Use Only - - - - - - - - - - - -

Copay _____

Diagnosis: Code_____

Diagnosis: Code_____