CLIENT INFORMATION

Name ______________________________ D.O.B. ____________

Address ____

City ______________________________ Zip ____________

H( )____________; W ( )______________; C ( ) ______________
(circle best # to reach you)

email ____________________; website ____________________

Spouse/Significant other ____________________; C ( ) ____________

Marital status (circle one) Married Separated Divorced Single Widow(er) Living-together

Children (name, age, [B] biological or [S] step-children) ______________________________
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How were you referred?

Website www.drjosielevine.com; Other ______________
Friend ______________________________
Professional (MD/PhD/JD) ______________________
Other ______________________________
Insurance ____________________ (circle one) PPO HMO
ID # ______________________
Policy Holder ______________DOB____________
EAP ______________________________

Employer ______________________ Occupation ____________

Current Medications/dosage ______________________________
Prescribed by ______________________Phone( )__________

How can I help you? ______________________________
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Consent for telehealth__________(initial) Credit/Debit card payment__________(initial)

Signature______________________________ Date______________