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CLIENT INFORMATION

Client's Name _____ Date of Birth _____

Married__Single__Widowed__Separated__Partnered__Divorced__

Name(s) and Age(s) of Children _____

Name of Spouse or Significant Other _____

Residence Address _____

City _____ State: _____ Zip Code _____

Billing address if other than above _____

Telephone Number (daytime) _____ (evening) _____

Email address: _____

Parent's Name if Client is a Minor _____

Person Responsible for Payment _____

Past or Current Occupation _____

Most Recent Employer _____

Nearest Relative (not residing with you) _____ Telephone # _____

Emergency Contact _____

Name	Telephone Number	Relationship
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Who referred you to this office? _____

Collection of insurance benefits is the responsibility of the client.
Signature of this form indicates agreement to be responsible for payment of services provided.

Signed

Date