ELLEN DYE, Ph.D. *Clinical Psychologist*

6325 Executive Boulevard
Rockville, Maryland 20852
(301) 933 5425

CLIENT INFORMATION FORM

Name of Client: _____

Date of Birth: _____/_____/_____ Age: _____

Address: _____

City: _____ ST: _____ Zip: _____

Email Address: _____

Home Phone Number: _____

Business Phone Number: _____

Cell Phone Number: _____

Occupation: _____ Highest Level of Education: _____

Marital Status: _____ Spouse's Name: _____

Referred by: _____

History of previous Treatment: _____

_____

_____

FOR CHILD AND ADOLESCENT CLIENTS ONLY:

Name of School Attended: _____

Grade Level: _____

Parents' Marital Status: _____

_____

Mother's Name and Address: _____

Mother's Home Phone Number: _____

Mother's Work Number: _____

Father's Name and Address: _____

Father's Home Phone Number: _____

6325 Executive Boulevard
Rockville, Maryland 20852
(301) 933 5425

Father's Work Number: _____

Siblings' Names and Ages:_____

_____

_____

_____

AUTHORIZATION FOR TREATMENT:

I have read Dr. Dye's Policy Statement and accept the terms as stated. I accept financial responsibility for services rendered to the extent that fees for these services are not paid by insurance. I authorize Dr. Dye to release information to my insurance company as necessary and authorize direct payment from my insurer to Ellen Dye, Ph. D.

_____ _____

Signature Date