Client Data

Patient Name: _____
Address: _____
City: _____ State___ Zip: _____
Phone: Home_____ Cell/Msg_____
E-Mail Address_____
Date of Birth: ___/___/_____ Social Security #_____-___-_____

Bill to: Self_____ Spouse_____ Parent_____ Other_____
Name:_____
Address:_____
City: _____ State___ Zip: _____
Phone: Home_____ Cell/Msg_____
Date of Birth: ___/___/_____ Social Security #_____-___-_____

Emergency Contact: _____
Relation: _____
Phone: Home_____ Cell/Msg_____

Primary Insurance Name: _____
Phone: _____
Policy/Claim #_____
Group #_____
Insured Name: _____
Auth #/ Pre-Cert # _____

Secondary Insurance Name: _____
Phone: _____
Policy/Claim #_____
Group #_____
Insured Name: _____
Auth #/ Pre-Cert # _____

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(206)473-2435
msibrava@aletheiapllc.com

Client Data

Please mark any that apply:

OK to leave voice messages: Yes / No

OK to send emails: Yes / No

OK to send email appointment reminders: Yes / No

OK to send text message (SMS) appointment reminders: Yes / No

I understand that not all forms of communication are secure and that some non-sensitive, but confidential information may disclosed in communication by telephone, email, or text message.
I understand that I can amend my requests limiting or extending methods of contact at any time by resubmitting this form.

Signature_____ Date _____