The Office Of:
ELLEN DYE, Ph.D. *Clinical Psychologist*
6325 Executive Boulevard
Rockville, MD 20852
Telephone (301) 770-0275
Fax (301) 770-0276

CLIENT INFORMATION FORM

CLIENT INFORMATION

Name: _____ DOB: _____/_____/_____ Pronoun (circle): She He They

Address: _____
Street Address City State Zip Code

Email Address: _____

Phone Numbers: Home_____ Work _____Cell_____

Occupation: _____ Highest Level of Education: _____

Marital Status: _____ Partner's Name: _____

Referred by: _____

History of Previous Treatment: _____

FINANCIALLY RESPONSIBLE PARTY'S INFORMATION (if different from the client)

Name: _____ Relation to Client: _____

Address: _____
Street Address City State Zip Code

Email Address: _____Phone Number(s): _____

For Child and Adolescent Clients

Name of School Attended: _____ Grade Level: _____

Siblings' Names and Ages: _____

Parents' Marital Status: _____

PARENT/GUARDIAN INFORMATION

Parent's Name and Address: _____

Phone Numbers: Home_____ Work _____Cell_____

Parent's Name and Address: _____

Phone Numbers: Home_____ Work _____Cell_____

AUTHORIZATION FOR TREATMENT:

I have read Dr. Dye's Policy Statement and accept the terms as stated. I accept financial responsibility for services rendered. I authorize the office of Dr. Dye to release information to my insurance company as necessary.

_____ _____
Client/Parent/Guardian Signature Date

_____ _____
Financially Responsible Party Signature Date