MARY A. BRADLEY LSCSW, LCSW
9401 Indian Creek Parkway, Suite 130
Corporate Woods Building 40
Overland Park, KS 66210
(816) 945-9440
E-mail: marybradleytherapy@hushmail.com

NEW CLIENT INFORMATION

Today's date ______________________________

Last name, first name, MI____

Address ____

City State Zip ____

Home phone ____________________________ **Work phone** ___________________________

Cell phone _____________________________ **E-mail address** ___________________________
Please indicate with "*"which phone number(s) may be left a detailed message

Date of birth ______________________________ **Relationship status** ______________________

Referred by (leave blank if not referred) ____

Your employer name ____

Address__________________________________ **City State Zip** ___________________________

Phone number_________________________ **How long employed** ________ **years** ________ **months**

Job title ________________________________ **Highest level of education** __________________

Emergency contact information: Name____

Phone Number _________________________________ **Relationship** ______________________

Health insurance name (only if provider is to bill insurance):

____

Insurance ID number ______________________________ **Group no** _______________________

Insured through employer? Yes ________ **No** _________

Full name of primary insured:____

Relationship _________________________________ **Date of birth** ________________________

(Insurance continued)
Primary insured's employer name and address (if insurance through employer):

Employer ____

Address____ **City , State, Zip** ______________________

Medical conditions, if any:

____

____

Date of last physical exam ______________________

Primary Care Physician ____________________________________ **Phone** ________________________

Current medications and dosage:

____

____

____

Contact information for psychiatrist or other health professional(s) involved in your care at this time (if any):

____

____

Have you seen a therapist in the past? If yes, describe when and for how long:

____

____

Reason for visit (be as brief or as lengthy as you like – turn over for more space):

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I authorize my therapist/service provider to contact my health insurance provider identified above if my insurance will be the payor to this mental health care provider. I authorize this service provider to obtain and provide information about my health and my health insurance coverage for the purpose of receiving payments and coordinating care.

Signed: ____ **Date:** ______________________