MARY A. BRADLEY LSCSW, LCSW
8301 State Line Road, Suite 200
Kansas City MO 64114
(816) 363-5600 ext. 3
Fax: (816) 363-5159
E-mail: mbradleytherapy@gmail.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):

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: _____

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