Clair L. Goldberg, Psy.D.
33 Plymouth Street, Suite 208
Montclair, NJ 07042
Licensed Psychologist #4139

NEW CLIENT INFORMATION

Please fill out this form and bring it to you first session.

CLIENT NAME:_____ BIRTHDATE:___/___/_____

HOME ADDRESS:_____ SSN#:_____

CITY:_____ ZIP:_____

TELEPHONE (CELL):_____ WORK:_____

(HOME):_____

EMAIL:_____

CAN LEAVE MESSAGE: CELL: Y/N HOME: Y/N WORK: Y/N EMAIL: Y/N

OCCUPATION:_____

PERSON RESPONSIBLE FOR PAYMENT:_____

PRIMARY CARE PHYSICIAN:_____

PERSON TO CONTACT IN EMERGENCY:_____

RELATIONSHIP:_____ TELEPHONE:_____

INSURANCE CARRIER:_____

PRIMARY INSURANCE HOLDER:_____ DOB: ___/___/_____

HOW DID YOU LEARN OF MY PRACTICE:_____

FEE AND CANCELLATION POLICY:

A 48 hour cancellation notice is required.

CLIENT AGREEMENT

I understand and agree that I am ultimately responsible for the balance on my account for all professional services rendered. I have read all the information on this sheet and certify the information I have provided is true and correct to the best of my knowledge.

SIGNED:_____ DATE: _____

(Client or Parent/Guardian if Client is a Minor)