James W. Caron, Ed.D., CGP
Connections Child and Adolescent Group Program
120 School Street
Lexington, MA 02421
(781) 863-5555

# Client Information Form

Today's date_____ Dx(office use):_____

Client's First Name, Middle Initial, Last Name _____

Client's Address (Number, Street) _____

City/State/Zipcode _____

Home Phone _____Work Phone _____

Work Phone #2 _____Cell phone _____

E-mail _____E-mail #2_____

Client's date of birth _____Client's current grade (if student)_____

**Insurance Information**

In whose name is insurance _____

Address of insured, if different from client _____

City/state/zipcode _____

Authorization number, if available _____

Number of sessions authorized _____

Name of insurance company_____

Insured's Identification Number (from card) _____

Insured's Date of Birth _____

Is there another health plan? If so, name of insurance and ID Number_____

Phone number of health insurance (note: Phone # for Mental Health if listed) _____

Name/address/phone of parent/guardian if not same as "insured" _____

_____

(Please continue on other side)

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# Client Information Form – provider contacts

(please note: we will need a signed release before contacting any of the providers listed below)

Client's current grade_____

School: Name _____

Address _____

Phone _____

Pediatrician _____

Address _____

Pone _____

Current psychotherapist _____

Address _____

Phone _____

Current psychopharmacologist or prescribing physician _____

Address _____

Phone _____

Other provider or specialist_____

Address _____

Phone _____

If psychological or neuropsychological evaluations have been done within the last three years, name of evaluator _____

Address _____

Phone _____