

Gary Seeman, Ph.D., Psychologist

Licenses : Washington PY 60478357, California PSY 19356

DX _____
Dr. Seeman to fill in

Client Registration Information

Client Name: _____ **Today's Date:** _____

Address: _____

Street

Apt#

City

State

Zip

Home: _____ **Mobile:** _____ **Work:** _____

messages ok?

messages ok?

messages ok?

Date of Birth: _____ Employer: _____

PRIMARY INSURANCE INFO: (Optional for private pay clients. Please indicate by check mark if same as above.)

Insurance Company/3rd Party Payer: _____

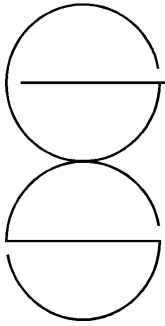
Name of Insured: _____ Date of Birth: _____

Insurance Co. Phone: _____

ID#: _____ Group# _____

3305 Main Street, Suite 304, Vancouver, WA 98663
Phone: 415.271.2350 • Fax: 360.887.2126

Email: drgaryse@gmail.com • Encrypted email: drgary@hushmail.com Website: www.drgaryseeman.com



Client Registration Information

(Asterisked (*) fields below are optional)

Person to contact in emergency or if you can't be reached: _____
Name

Address: _____
Street City State Zip

Relationship to you: _____
Phone(s): _____

Your Occupation: _____ How long on present job? _____

Email: _____ Place of birth: _____

Are you:

Married/Partnered

Single

Separated

Divorced

Widowed

Living with spouse/partner? Yes No If yes, how long? _____

*Ethnicity: _____

Religious/Spiritual Orientation (asked to better understand your worldview):

Do you want religion/spirituality included in psychotherapy? Yes No Not sure

*Do you have a work related problem? Yes No

Are you currently on: Workers compensation? SSI? State disability?