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### Adult Client Information Form

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age of Client: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Primary Address: (street/city/state/zip) \_\_\_\_\_

Emergency Contact Information: \_\_\_\_\_

Additional Contact Information: \_\_\_\_\_

Name of Current Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

### Insurance Information

Insurance Company: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Birthdate: \_\_\_\_\_

Subscriber's Social Security # \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_

Member ID# \_\_\_\_\_ Group# \_\_\_\_\_

Specialist Copay: \_\_\_\_\_ Specialist Coinsurance: \_\_\_\_\_

**PLEASE NOTE:** In an effort to facilitate communication, D J Koehn Consulting Services Inc. sends **TEXT MESSAGE** confirmations the business day prior to your scheduled appointment. Our office will also **E-mail** receipts for payments or account statements to the provided E-mail address. If you would like to use a phone number or E-mail address other than the ones listed above to receive copies of your receipts/statements, please list them on the line below. If you **do not** want to receive these communications, please write "I decline" on the line below:

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