Chantelle L. Taylor-Bittings, LCPC
Chicago, IL 60643

Client Information Form

Name: _____

Date of Birth: _____

Address: _____

_____

_____

Phone Number: _____

_____

Insurance Information

Insurance Type: _____

Insurance ID: _____

Provider Name and Phone Number:

Primary Care: _____

Current Psychiatrist: _____

In Case of Emergency:

Name: _____

Relationship to you: _____

Phone Number: _____

Referral:

Referred by: _____