**Johanna R. Rayman, LCSW, GCFP - Independent Practitioner**
5404 N Montana Ave · Portland, OR 97217 · 503-380-5437

**CLIENT INFORMATION** Today's date _____

Date of birth _____ Gender: for insurance- _____ identity/ pronouns- _____

Legal Name (to use with insurance) _____

Preferred Name (if different) _____

Street Address _____

City _____ State _____ Zip _____

Phone

1_____ ☐primary number ☐ok to leave msg ☐ok to text*

2_____ ☐primary number ☐ok to leave msg ☐ok to text*

Email address*: _____

***Please note that email is not a secure method of communication.***

How would you like to receive appointment reminders? ☐Text ☐Phone ☐Email

Who referred you? _____

**EMERGENCY CONTACT / PARTNER / GUARDIAN**

Who should I contact in an emergency? _____

Relationship to client _____

Phone: 1_____ 2_____ 3_____

*In the case of an emergency, I consent for my therapist to contact the person listed above.*

_____ _____
Signature Date

Primary Care Physician _____

Clinic _____ Phone_____

Allergies or medical alerts _____

_____

**INSURANCE INFORMATION**

**Primary Health Insurance** _____

**Subscriber** name (if not the client) _____

Client relationship to subscriber _____ **Subscriber** date of birth _____

ID #_____ Group/Policy # _____

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**Additional Health Coverage** _____

**Subscriber** name (if not the client) _____

Client relationship to subscriber _____ Subscriber date of birth _____

ID #_____ Group/Policy # _____

**Type of additional coverage:** ☐Secondary Insurance ☐ CVC ☐ OHP ☐ EAP ☐ Care Assist