

**Denise C. Wall, LCSW**  
610 Main Street | P.O. Box 514  
Odessa, Delaware 19730  
302-376-5259 Office  
302-689-4474 Fax

**CLIENT / PATIENT FACE SHEET** (Please print clearly)

Client/Patient Name: \_\_\_\_\_  
Last Name First Name MI

Mailing Address: \_\_\_\_\_  
Post Office Box or Street Address  
\_\_\_\_\_  
City / State / Zip Code

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

If client is a minor:  
Parent / Guardian Name: \_\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_

**Emergency Contact Information:**

Emergency Contact Person Name & Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Relationship to Patient/Client: \_\_\_\_\_

**Employer Information:**

Employer Name: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone: (\_\_\_\_) \_\_\_\_\_

**Insurance Information:**

Insurance Company Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Client/Patient: \_\_\_\_\_

Member ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Co-pay Amount: \$ \_\_\_\_\_ per visit

**Acknowledgement of Notification of Privacy Practices**

I, \_\_\_\_\_, have received **the Notice of Privacy Practices** from the office of Denise C. Wall, LCSW.

Client/Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*In lieu of patient signature, I state that \_\_\_\_\_ has been given a copy of our current Notice of Privacy Practices.*

Staff Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_