METRO NY DBT
CENTER

NEW CLIENT FACE SHEET

Date: ________________ Name: ____

DOB: ________________ Age: __________________ Gender: ______________________________

Address: ____

City: ____________________________ State: __________________________ Zip: __________

Phone: ______________________________________ Mobile: ______________________________

Email: ____

School (if applicable): ____

Grade: ____

School Contact: ____

Responsible Party: (Billing statement will be sent to this person.) or Same as above

Name: ____

Relation to the client: ____

Address: ____

City: ____________________________ State: __________________________ Zip: __________

Phone: ______________________________________ Mobile: ______________________________

Email: ____

Referred by: ____

Contact number: ____