Registration Information

Please Print Clearly THIS SHEET MUST BE FILLED IN COMPLETELY

Date_____ Client's Social Security # _____
Client's Name _____ MI _____
Address _____ City _____ State_____ Zip _____
Telephone (Home) _____(Cell)_____ (Work)_____
*Preferred Number to contact_____
Birthdate _____/_____/_____ Age _____ Gender _____F _____M Race _____
Name of Guardian _____ Phone _____
Address _____ City _____ State _____ Zip _____
Person Responsible for Payment _____ Soc. Sec. # _____

EMERGENCY INFORMATION

In case of emergency, contact:
Name _____ Relationship _____ Phone _____
Physician _____ Phone _____
Address _____ City _____ State _____ Zip _____
Psychiatrist _____ Phone _____
Address _____ City _____ State _____ Zip _____
Current Medications _____
Allergies _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Phone _____
Spouse: Place _____ Phone _____

INSURANCE INFORMATION

Primary Insurance _____
Phone_____
Contract/ID# _____
Group/Acct#_____
Subscriber_____
Subscriber Date of Birth_____
Client's relationship to Subscriber
___Self ___Spouse ___Child ___Other_____

Secondary Insurance _____
Phone_____
Contract/ID# _____
Group/Acct# _____
Subscriber _____
Subscriber Date of Birth_____
Client's relationship to Subscriber
___Self ___Spouse ___Child ____Other_____

PROVISIONS: Client pays $_____ Deductible amount Amount satisfied: $_____
Insurance pays_____ % for visits____–____ and_____ % for visits____–____
Type(s) of providers covered: _____ Supervision: _____
Prior authorization needed: _____
Effective date: _____ Policy anniversary: _____
Coverage for testing: _____ Annual limit: _____

REFERRAL SOURCE

How did you hear of our clinic (please check appropriate box and describe)
____Doctor's office_____
____School_____
____Search Engine_____
___Psychology Today/Good Therapy (circle)
____Community_____
____Website_____
____Other_____