Registration Information

Please Print Clearly THIS SHEET MUST BE FILLED IN COMPLETELY

Client's Name _____ Date_____
Address _____
City _____ State_____ Zip _____
Telephone:(Cell) _____ (Work)_____(Home)_____
*Preferred Number to contact_____
Email Address: _____
Birthdate _____/_____/_____ Age _____ Gender _____Race _____
Name of Guardian(s) _____ Phone _____
Email Address (if different from above) _____
Address _____City _____State _____Zip _____
Person Responsible for Payment _____ Soc. Sec. # _____

EMERGENCY INFORMATION In case of emergency, contact:

Name _____ Relationship _____ Phone _____
Physician _____ Phone _____

Psychiatrist (if applicable) _____ Phone _____

Current Medications_____
Allergies _____

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

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

INSURANCE

Primary Insurance _____
Contract/ID# _____Group/Acct#_____
Subscriber name and date of birth_____
Client's relationship to Subscriber: ___Self ___Spouse ___Child ___Other
Secondary Insurance _____Subscriber name and DOB_____

REFERRAL SOURCE

How did you hear of our clinic?

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