Registration Form

Date_____ Home Phone_____

Cell Phone _____

Email Address_____

*May we contact you via email as it is not considered a confidential form of communication?
Yes_____ No_____

Name_____
Street Address_____
City_____State_____Zip Code_____
Date of Birth_____Age_____ Male_____Female_____

Employer_____
Is it ok to contact you at work _____work phone number_____
May we leave a message for you at home_____
Referred by_____
Emergency Contact Name_____
Relationship to you_____
Emergency contact's phone number_____

Spouse or Person holding insurance_____
Home address if different from yours_____
Relationship to Client_____

Primary Insurance Coverage:
Name of Insurance Company_____
Name of Subscriber_____Subscriber's birthdate_____
Member ID #_____ Group #_____
Phone number on back of card for Behavioral Health_____

Secondary Insurance Coverage:
Name of Insurance Company_____
Name of Subscriber_____Subscriber's birthdate_____
Member ID#_____Group #_____
Phone Number on back of card for Behavioral Health

_____ _____

Signature of Client Date