

CLIENT REGISTRATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (please indicate which number is best to reach you at and leave a voice message)

Home _____ Work _____ Cell _____

DATE OF BIRTH: _____ AGE: _____ SSN: _____

MARITAL STATUS: S M D W NAME OF SPOUSE/PARTNER: _____

Emergency Contact: _____
Name Phone # Relationship

How did you find out about me?

MD _____ Google Search Yahoo Search Friend Therapist Website

Other Internet Search/Website _____ Other _____

INSURANCE INFORMATION

Complete this section if you plan on using your insurance. Please note that the majority of insurance carriers reserve the right to access your records as a way to ensure proper utilization and treatment. In most cases, your insurance policy and my agreement with them allows for this record review. If you do not want your personal information shared with your insurance company you can elect to pay for services yourself.

Primary Insured (if self leave blank): _____

Primary Insured date of birth and SSN: _____

Insurance Company Name: _____

Insurance Company Address: _____
Street #/POB City State Zip

ID#: _____ Group#: _____ Authorization: _____