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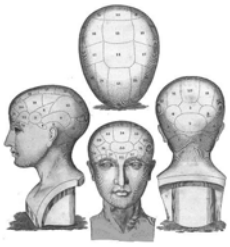

PATIENT REGISTRATION FORM

CLIENT INFORMATION				
Name		Referred by		
Street				
City		State	Zip	
Phone (H)	(W)		Other	
Date of Birth	Gender ◯ Male ◯ Female		SSN	
Marital Status	◯ Single	◯ Married	◯ Divorced	◯ Other
Relationship to Policyholder	◯ Self	◯ Spouse	◯ Child	◯ Other
Employment Status	◯ Full-Time	◯ Part-Time	◯ Unemployed	
School Status	◯ Full-Time	◯ Part-Time	◯ Does not Attend School	
Is treatment related to	◯ Employment	◯ Auto Accident	◯ Other Accident	◯ N/A

POLICYHOLDER/INSURANCE INFORMATION ***If secondary coverage is available, please request additional insurance form***			
Name	SSN #		Group #
Street	Member ID #		
City	State		Zip
Phone (H)	(W)		Other
Date of Birth	Gender ◯ Male ◯ Female		
Insurance Company	Phone		
Street	City	State	Zip
Employer	Authorization #		

FOR OFFICE USE ONLY		
Intake Date	Referral	Code
Client Amount/Copay 1st Visit	Primary Dx	
Client Amount/Copay 2nd Visit	Other Payment Information	
Benefits	Deductible	Amt. Met
Utilization Review	Max $/yr	Max #/yr

In order for us to bill your insurance company we must have complete information about your insurance. If there is some information that you do not have available at this time, please call it in to the office as soon as possible. If we are lacking information, we are unable to bill your insurance company. You will be held financially responsible for all charges incurred.