ELICIA SEAY, PH.D., LLC
CLIENT REGISTRATION FORM

5250 Cherokee Ave., Suite 410, Alexandria, VA 22312
(703) 354-1144 / (703) 831-8752 (fax)

Please provide your current insurance card(s) so that a copy can be made

Patient Information:

Patient Name (full): _____ Sex: M___F___

DOB:___/___/_____ Age:_____ Marital Status: ☐single ☐married ☐divorced ☐widowed ☐ partnered

Address: _____ City_____ State_____ Zip Code _____

Home Phone: (____)_____ Cell phone: (___)_____

Employer: _____Work phone: (___)_____

E-Mail: _____

Please Note: Email correspondence is not considered to be a confidential medium of communication

Referred by (if any):_____ may I thank them for the referral? ☐yes ☐no

Spouse Information:

Name: _____ DOB:___/___/_____ E-Mail: _____

Address: _____ Home Phone : (____)_____

Employer: _____Work phone: (___)_____ Cell phone: (___)_____

Reason For Today's Visit: _____

_____

Primary Insurance Information:

Insurance Co. Name: _____ Policy ID#: _____ Group #: _____

Address: _____ Phone No.: (____)_____

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Does your plan require referral? ☐ yes ☐ no Copay Amount: $_____

Secondary Insurance Information:

Secondary Ins. Co. Name: _____ Policy ID#: _____ Group #: _____

Address: _____ Phone No.: (____)_____

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Does your plan require referral? ☐ yes ☐ no Copay Amount: $_____

Emergency Contact: _____Relationship to patient:_____ Emergency Contact #:_____

Client Attestation: By signing this document, I am affirming that all information supplied is accurate. I have received and had the opportunity to review a notice of privacy practices from Elicia Seay, Ph.D.,LLC.

Patient Signature: _____
Date: ____/____/_____

Medical and Psychiatric History

List any ongoing medical conditions or problems:

_____

_____

_____

_____

Previous therapy experience including any psychiatric hospitalizations:

_____

_____

_____

List any medication you are presently taking:

_____

_____

_____

_____

Current prescribing psychiatrist or physician:

_____

_____