

Client Registration Form

Patient Name:	Social Security #:
Street Address:	Date of Birth:
City, State, Zip Code:	Home Phone:
Gender/ Ethnicity:	Work Phone:
Email Address:	Mobile Phone:
Primary Physician:	Psychiatrist (if any):
Emergency Contact:	Emergency Contact Phone:
How did you hear about us?	Marital Status:

**Responsible Party is the person who will be paying the per-session fee for services
(leave blank if same as patient)**

Responsible Party:	Home Phone:
Street Address:	Work Phone:
City, State, Zip Code:	Mobile Phone:
Relationship to Patient:	Responsible Party SSN:

Insurance or EAP (Employee Assistance Program) Information

Primary Insurance:	Policy Holder Name:
Company Address:	Policy Holder Date of Birth:
City, State, Zip Code:	Identification Number:
Company Phone:	Policy/Group Number:

Employer:	Policy Holder SSN:
Employer Address	Employer's Phone: Contact Y / N:
EAP	EAP Reference #
Print Name	Signature
Date	