Child & Family Counseling Center
Patient Registration

Patient Name____________________________________ Date of Birth_____/______/_______ Age_________

Street Address____SS#_____________________ Male/Female

City____________________________ State________ Zip___________ Marital Status S M Sep D W

Phone: Home_______________________Work______________________Cell__________________________

Has patient been treated here previously? YES NO If yes, when?____________________________________

Who referred you to the Child & Family Counseling Center?____

Responsible Party (if different from above)

Address____

Phone____

Emergency Contact_________________________ Phone__________________Relationship_________________

Primary Insurance Company____

Policy Holder___________________________DOB:______________ Social Security #_________________________

Policy Number____ Group Number_________________________

Relation to Patient______________________________

Employer Name_____________________________________ Employer City/State:_____________________________

Copay/Coinsurance______________________Deductible_______________________ Deductible met? YES NO

Is patient covered by another insurance policy? NO YES If yes, please enter name of second company below:

Secondary Insurance Company____

(Please note that we do not file secondary insurance claims, but can give you a receipt for you to file.)

Primary Care Physician: ________________________________ City__________________________________

Phone____ Fax__________________________________

Do we have your permission to?

Leave a message on your answering machine at home? ____YES ____NO

Leave a message at your place of employment? ____YES ____NO

Today's Date___________________________