Child & Family Counseling Center
Patient Registration 2020

Patient Name_____ Date of Birth_____/_____/_____ Age_____

Responsible Party (If different)_____

Street Address_____ Male/Female/Other _____

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?_____

Emergency Contact_____ Phone_____Relationship_____

Primary Insurance Company_____

Policy Holder_____DOB:_____

Policy Number_____ Group Number_____

Relation to Patient_____

Employer Name_____ Employer City/State:_____

Copay/Coinsurance_____Deductible_____ Deductible met? YES NO

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_____