Child and Family Counseling Center
Patient Registration 2024

Patient Name ______________________________ Date of Birth _______________ Age _____

Male/Female/Other __________________________ Marital Status S M Sep D W

Responsible Party (if different) ____

Street Address ____

City ______________________________________ State __________ Zip _________________

Phone: Home: ____________________ Work ____________________ Cell ____________________

Has the patient been treated here preciously? YES NO If yes, when? ____________________

Emergency Contact ______________________________ Relationship ______________________

Phone __________________________

Primary Insurance ____

Policy Holder Name ______________________________________ DOB __________________

Policy Number ________________________________ Group Number _____________________

Relation to patient ____

Employer Name ___________________________ Employer City/State ____________________

Primary Care Physician ______________________________ City _________________________

Phone ______________________________________ Fax _______________________________

Do we have 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 _____________________________