Child and Family Counseling Center
Patient Registration 2025

Today's Date_____

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 previously? YES NO If yes, when?_____

Emergency Contact_____Relationship_____

Phone # _____

Primary Insurance_____

Policy Holder Name_____DOB_____

Policy Number_____Group Number_____

Relationship to the Patient_____

Employer Name_____Employer City/State_____

Primary Care Physician_____

Phone Number_____Fax Number_____

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