

**Registration Form**

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Gender (circle one): M F  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Marital Status (circle one): Single Married Separated Divorced  
Spouse's Name: \_\_\_\_\_  
Children in Family (names, ages, occupation): \_\_\_\_\_  
Primary Care Physician (PCP): \_\_\_\_\_ Phone: \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_  
Referred by: \_\_\_\_\_ May I thank this person? Yes \_\_\_ No \_\_\_  
Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information** (please bring card & ID to visit)

Medical Insurance Company: \_\_\_\_\_  
Membership Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Subscriber's Full Name: \_\_\_\_\_ DOB Subscriber: \_\_\_\_\_  
Relationship to Subscriber: \_\_\_\_\_  
Secondary Insurance Company: \_\_\_\_\_  
Membership Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Subscriber's Full Name: \_\_\_\_\_ DOB Subscriber: \_\_\_\_\_  
Relationship to Subscriber: \_\_\_\_\_

**Complete box if client is minor:**

Parent/Legal Guardian Name: _____
Address: _____ Phone: _____
Occupation: _____ Employer: _____
Work Address: _____ Work Phone: _____
Minor's School: _____ Grade: _____

I hereby authorize Life Counseling, LLC to furnish information to insurance carriers, government agencies and/or third party billing entity concerning my illness and treatments and I hereby assign to them all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_