

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: _____