

Patient Registration Form

Patient Demographic Information

Patient Name:	Social Security #:
Street Address:	Date of Birth:
City, State, Zip Code:	Home Phone:
Gender:	Work Phone:
Email Address:	Mobile Phone:
Primary Physician:	Psychiatrist (if any):
Emergency Contact Person:	Emergency Contact Phone:
How did you hear about us?	Marital Status:

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)

Responsible Party:	Home Phone:
Street Address:	Work Phone:
City, State, Zip Code:	Mobile Phone:
Relationship to Patient:	Responsible Party SSN:

Insurance Information

Primary Insurance:	Policy Holder Name:
Company Address:	Policy Holder Date of Birth:
City, State, Zip Code:	Identification Number:
Company Phone:	Policy/Group Number:

Employer:	Policy Holder SSN:
Secondary Insurance:	Policy Holder Name:
Company Address:	Policy Holder Date of Birth:
City, State, Zip Code:	Identification Number:
Company Phone:	Policy/Group Number:
Employer:	Policy Holder SSN:

Signature: _____

Date: _____