CLIENT REGISTRATION FORM

***C**ommunity **T**herapy **S**ervices*

Please list any allergies:

CLIENT'S NAME (First, Middle, Last)	DATE OF BIRTH	GENDER	RELATIONSHIP TO INSURED
PARENT/GUARDIAN OF DEPENDENT NAMED ABOVE	MARITAL STATUS		DATE OF BIRTH
STREET ADDRESS	CONFIDENTIAL PHONE NUMBER ( ) (home or cell number where messages may be left)		
CITY - STATE - ZIP			
EMPLOYER / OCCUPATION		EMPLOYER'S PHONE NUMBER ( )	
EMPLOYER'S ADDRESS			
SPOUSE'S NAME (or other responsible party)	DATE OF BIRTH	EMPLOYER	
EMPLOYER'S ADDRESS		EMPLOYER'S NUMBER ( )	
E-MAIL :	HOW DID YOU HEAR ABOUT US?		

EMERGENCY CONTACTS

IN CASE OF EMERGENCY NOTIFY	PHONE # ( )	CELL PHONE # ( )
PRIMARY CARE PHYSICIAN	PHYSICIAN'S PHONE NUMBER ( )	

INSURANCE INFORMATION

INSURANCE COMPANY'S NAME ☐HMO ☐PPO		
ADDRESS (CITY-STATE-ZIP)		
PHONE NUMBER ( )	NAME OF INSURED	
RELATIONSHIP	ID NUMBER	GROUP NUMBER

*I understand and agree that (regardless of my insurance policy), I am responsible for the entire balance on my account for all services provided to the client (or myself).
*I have completed all the questions above and I certify to the best of my knowledge, the information is correct and true.
* I will notify this office in case of any changes to health insurance or any of the above.

SIGNATURE: _____ DATE: _____