

# REGISTRATION FORM

(Please Print)

Today's date: \_\_\_\_\_ PCP: \_\_\_\_\_

## PATIENT INFORMATION

Client's **Last Name:** \_\_\_\_\_ **First:** \_\_\_\_\_ **Middle:** \_\_\_\_\_  Mr.  Miss  Mrs.  Ms. Marital status \_\_\_\_\_

Is this your legal name?  If not, what is your legal name? \_\_\_\_\_ **Birth date:** \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Street address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_ Home phone #: \_\_\_\_\_  
( )

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ Cell phone #: \_\_\_\_\_  
( )

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work phone #: \_\_\_\_\_  
( )

How did you hear about us?  Dr.  Insurance Plan  Hospital  
 Family  Friend  Website/Internet  Yellow Pages  Other

## INSURANCE INFORMATION

(Please provide your insurance card to the therapist.)

Person responsible for account: \_\_\_\_\_ Birth date: \_\_\_\_\_ Address (if different): \_\_\_\_\_ Home phone #: \_\_\_\_\_  
( )

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer address: \_\_\_\_\_ Employer phone #: \_\_\_\_\_  
( )

Is this patient covered by insurance?  Yes  No Self-Pay \_\_\_\_\_

**Primary Insurance Company:** \_\_\_\_\_

**Subscriber's Name:** \_\_\_\_\_ Subscriber's S.S. no.: \_\_\_\_\_ **Birth date:** \_\_\_\_\_ **Group #:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_ Co-payment: \_\_\_\_\_  
/ / \$

Patient's relationship to subscriber:  Self  Spouse  Child  Other

Name of secondary insurance (if applicable): \_\_\_\_\_ Subscriber's name: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Patient's relationship to subscriber:  Self  Spouse  Child  Other

## IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Home phone #: \_\_\_\_\_ Cell/Work phone #: \_\_\_\_\_  
( ) ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to New Transitions Counseling Center, Ltd. I understand that I am financially responsible for any balance not paid by insurance. I also authorize New Transitions Counseling Center, Ltd. or insurance company to release any information required to process my claims.

\_\_\_\_\_  
*Patient/Guardian signature*

\_\_\_\_\_  
*Date*