Patient Registration Form

Therapist: _____

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: _____