Sheryl R. Jacobs, Ph.D., P.C.

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REGISTRATION FORM FOR ADULTS

CLIENT INFORMATION								
Name					Referred by:			
Street								
City					State		Zip	
Home Phone					Cell Phone			
Work Phone					Email:			
Date of Birth					Gender ☐ Male ☐ Female			
Relationship to Policyholder	**Self**	☐	**Spouse**	☐	**Child**	☐	**Other**	☐
Employment Status	**Full Time**	☐	**Part Time**	☐	**Unemployed**			☐
School Status	**Full Time**	☐	**Part Time**	☐	**Does not attend school**			☐
Is treatment related to	**Employment**	☐	**Auto Accident**	☐	**Other Accident**	☐	**N/A**	☐

Dr. Jacobs does not participate with any insurance plans, and her practice is a "fee for service" practice. Although full payment is expected at the time of the visit, Dr. Jacobs can file a claim for the services provided to you. However, if additional phone calls are required due to claim issues, the client is responsible for making any follow up calls or additional corrected claim filing. You can also be provided with a monthly statement that includes all necessary information to file a claim yourself or to use with your Health Service Account or Flex Spending Account. ONLY PROVIDE INSURANCE INFORMATION IF YOU WANT SHERYL R. JACOBS PH.D. P.C. TO FILE A CLAIM FOR YOU.

POLICYHOLDER/INSURANCE INFORMATION			
Name			Group #
Street	Member ID #.		
City	State		Zip
Phone (H)	(W)		Other
Date of Birth	Gender M ☐ F ☐		
Insurance Company	Phone		
Street	City	State	Zip
Employer	Authorization #		

Client's Name_____**Date of Birth**_____

Physician_____
Phone_____
Physician's Address_____
_____

Other Family Members	Relationship	Date of Birth

Marital Status ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Single**

How long married?_____ **How long divorced?**_____

Person to contact in case of emergency:
Name:_____
Phone Number _____
Relationship_____

School level completed_____ **Occupation** _____

Hospitalizations_____

Allergies_____

Chronic Medical Conditions (i.e. asthma, ear infections)_____

Current Medical Concerns_____
_____

Current Medications and Dosage_____
_____

Client's Name_____**Date of Birth**_____

Please list the problems with which you want help:

1_____

2_____

3_____

4_____

Have you received any other therapy or special treatments (psychological counseling, psychiatric help, speech therapy, medications, diets, etc.)? ☐ **Yes** ☐ **No**

If so, please describe below:

Approximate Date(s)	Type of Treatment	Name/Address of Provider

Family History: ***Following is a list of problems that sometimes run in families. We are interested in whether anyone else in the family has had any problems in these areas.***

Family History	Mother	Father	Brother(s)	Sister(s)	Others (e.g. aunt)
Hyperactive as child					
Behavior Problems					
In trouble as a teen					
Trouble learning to read					
Trouble learning to write					
Trouble with math					
Kept back in school					
Drug/alcohol Problems					
Anxiety					
Depression					
Psychiatric Hospitalization					

Signature_____ *Date* _____