

Comprehensive
Counseling Services

Patient Registration

Please Print

Patient Name _____
Last First Middle

Address _____ City _____ Zip _____

Home Phone _____ Work _____ Ext _____ Cell _____

Birthdate ____ - ____ - ____ Social Security # ____ - ____ - ____ Gender _____ Marital Status _____

Employer _____

Referred by _____ Emergency Contact _____ Phone _____

If the patient is a child, please give additional information:

Mother/Guardian's Name _____ Father/Guardian's Name _____

Are biological parents: Married Separated Divorced Other

Who has legal custody of the child? _____

Child lives with _____ Relationship _____

Child is carried on the insurance of (Please check all that apply):

Biological Mother Biological Father Step Mother Step Father Grandparent Adoptive Parent Other

Do You Have Insurance Coverage? Yes No

Primary Insurance Information:

Insurance Company Name _____ Phone _____

Subscriber _____ Subscriber's Birthdate _____

Address if different than above _____ City/State/Zip _____

Member ID # _____ Group # _____ Effective Date _____

Relationship _____ Subscriber SS # _____

Subscriber's Employer _____

Secondary Insurance Information:

Insurance Company Name _____ Phone _____

Subscriber _____ Subscriber's Birthdate _____

Member ID # _____ Group # _____ Effective Date _____

Do you or your partner have any other insurance coverage: Yes No

The above information is correct and all insurance information is listed.

Date _____ **Signed** _____