ADULT REGISTRATION FORM

Name: _____ _____ **Date:**_____
(First) (M.I.) (Last)

CURRENT ADDRESS	**DATE OF BIRTH:**	**GENDER**:
Address Line 1: _____	_____/_____/_____	❑ M
Address Line 2: _____	**AGE**: _____	❑ F
City: _____ State: _____ Zip code:_____	**Email**: _____	

TELEPHONE CONTACT INFORMATION

Please indicate the number at which you prefer to be contacted first and indicate if a message can be left at that number.		
❑	Home: ( ) -	OK to leave message? YES _____ NO _____
❑	Cell: ( ) -	OK to leave message? YES _____ NO _____
❑	Work: ( ) -	OK to leave message? YES _____ NO _____
❑	Other: ( ) -	OK to leave message? YES _____ NO _____

INSURANCE INFORMATION

Insurance Provider:	ID Number AND Group Number
Provider Address: _____ City: _____ State: _____ Zip code:_____	Provider Phone Number: ( ) -
Insured Person (If other than client):	Relationship of insured to client:
Insured Person's Date of Birth:	
Employer:	Employer Phone: ( ) -
Employer Address:	

DEMOGRAPHICS

Marital Status	❑ Single	❑ Divorced # Years_____	❑ Married # Years_____	❑ Living as Married # Years_____	❑ Separated # Years_____	❑ Widowed # Years_____

Spouse/Partner Name: _____
If therapist is unable to reach you, is it OK to contact your spouse/partner? YES _____ NO _____

Employment School Status	Are you currently employed? YES _____ NO _____	Are you currently enrolled in school? YES _____ NO _____
	If yes, please specify: ❑ Full-time ❑ Part-time ❑ Retired ❑ Seasonal ❑ Unemployed ❑ Other:_____	If yes, please specify: ❑ Full-time ❑ Part-time ❑ Non-credit courses ❑ Trade/vocational ❑ Other: :_____
	Employer Name:	School/University Name:

EMERGENCY CONTACTS

Please list at least ONE person that can be contacted by your therapist in the event of an emergency.

Name: _____ Address: _____ Phone: _____ Relationship to you: _____	OK to leave message? YES _____ NO _____
Name: _____ Address: _____ Phone: _____ Relationship to you: _____	OK to leave message? YES _____ NO _____

PRIMARY CARE PHYSICIAN

Current Physician Name: _____ Address: _____ Phone: _____ Fax Number: _____	Date of last physical exam:

REFERENT INFORMATION

By whom were you referred?	Phone:

PRESENTING PROBLEM

Please discuss why you are seeking therapy at this time. _____
_____
_____

Consent for Release of Information

By signing below, I am authorizing my Protected Health Information (PHI) to be used and disclosed to my insurance company or other private payors for billing purposes.

_____ _____
Client Signature Date

_____ _____
Witness/Therapist Date