

PATIENT REGISTRATION FORM

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| CLIENT INFORMATION |
| Last name, first name: | Nickname: |
| Date of Birth: | Gender: | PCP name:Number: |
| Address/Zipcode: |
| PARENT/GUARDIAN INFORMATION |
| Father name:  | Preferred phone: | Email: |
| Mother name:  | Preferred phone:  | Email: |
| Therapist being seen today: | Who referred you to us? |
| INSURANCE INFORMATION: copy of insurance card is required |
| Primary insurance: | Policy number: | Group number: | Subscriber name: |
| Subscriber Date of Birth/Client Relationship to Subscriber: | Specialty copay: |
| Secondary insurance: | Policy number: | Group number: | Subscriber name: |
| Subscriber Date of Birth/Client Relationship to Subscriber: | Specialty copay: |
| GUARANTOR INFORMATION |
| Guarantor name: | Guarantor DOB: | Guarantor address: |
| Guarantor employer: | Employer address:  | Employer phone: |
| EMERGENCY CONTACT |
| Name: | Relationship to client: | Phone number: |

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Dr Deb’s Center for Child and Family Development. I understand that I am financially responsible for any applicable deductibles or copays required by my insurance carrier. I also authorize Dr Deb’s Center for Child and Family Development and/or my insurance company to release any information required to process my claims.

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| Client or Parent/Guardian signature (if under 18): Date: |