A white cover with a logo

Description automatically generated

PATIENT REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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: |