Client Registration Form

First name: _____ MI _____ Last Name: _____

Date of Birth: _____ Age: _____ Sex: F M Any known allergies: Y N

Address: Street: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone Numbers: Cell: _____ Home: _____

If client is a minor: Parent Name: _____ phone: _____

Parent Name: _____ phone: _____

Email addresses: _____

_____

Primary Care Physician or Pediatrician: _____

Primary Insurance Company Name: _____

ID#: _____Group #: _____

Subscriber Name: _____ Date of Birth: _____

Insurance Address: _____

Insurance Phone Number: _____

Secondary Insurance Company Name: _____

If the person responsible for the bill is not the client, please fill in this section:

Person responsible for the bill: _____

Address: _____

Phone Number: _____

Assignment and Release:

I hearby authorize my insurance benefits to be paid directly to Christina J. Allen, LICSW, and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of information needed to verify the medical necessity for my evaluation and treatment to my insurance.

Client signature: _____ Date: _____