Ann Bowen, LMFT, LPC, NCC
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REGISTRATION FORM

Today's date: _____ Referred by: _____

PATIENT INFORMATION

Patient's last name: _____ First:_____ Middle: _____

Gender: _____ Patient birth date:_____ Age:_____ Marital status (circle): Single / Mar / Div / Sep / Wid

Address Street: _____

City: _____ State: _____ Zip code: _____

Preferred Phone No: _____ Reminders: text or email? _____ If text, Carrier: _____

Email Address for contact: _____
Please note: Email or text correspondence is not considered to be a confidential medium of communication.

Patient Social Security: _____Patient occupation: _____

Patient Employer: _____ Employer phone: (_____) _____

Full name of children in birth order with ages (if applicable): _____

_____

Others living in home and their relationship to patient: _____

Personal physician: _____ Phone: (_____) _____

List of all medications patient is currently taking: _____

_____

Has patient been hospitalized in past 5 years? If yes, for what reason? _____

Has patient had previous counseling, psychological or psychiatric treatment? _____ Dates:_____

Where?: _____

EMERGENCY CONTACT INFORMATION

Name of local friend or relative (not living at same address): _____

Relationship to patient: _____Home phone : (_____) _____ Work phone : (____) _____

The above information is true to the best of my knowledge.
I authorize my insurance benefits be paid directly to Ann Bowen, LMFT, LPC, NCC c/o Gateway Counseling.
I understand that I am financially responsible for any amount not covered by insurance.
I also authorize Ann Bowen, Gateway Counseling, or Insurance Company to release any information concerning my illness and treatments required to process my claims.

Patient/Guardian Signature: _____ Date: _____ 3/19