REGISTRATION FORM

(Please provide insurance card and drivers license to receptionist)

Today's date:	Referred by:

PATIENT INFORMATION

Patient's last name: First: Middle:			Sex: ❑Male ❑ Female	Age:	Patient birth date:
Patient marital status (circle one) Single / Mar / Div / Sep / Wid		Patient Social Security:		Patient Cell: ( )	Home phone: ( )
Street address:		City: State:			Zip code:
Patient occupation:	Patient employer:				Employer phone: ( )

Email address:
Full name of children in birth order (if applicable):
Others living in home and their relationship to patient:

Personal physician:	Address:	Phone: ( )
Current therapist:	Address:	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 psychological or psychiatric treatment? Where and when?

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone : ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone: ( )

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no:	Birth date: / /	Group no:	Policy no:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

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 Shannon Brewer. **I understand that I am financially responsible for any amount not covered by insurance**. I also authorize Shannon Brewer or insurance company to release any information concerning my illness and treatments required to process my claims.

Patient/Guardian signature *Date*