Registration Form

Forest Licensed Clinical Social Work, P.C.

DATE_____

PATIENT NAME_____**DATE OF BIRTH**_____ **Sex** _____

STREET ADDRESS_____

CITY_____ **STATE**_____ **ZIP**_____

SS#_____**EMPLOYER**_____

HOME PHONE # _____**WORK PHONE #**_____ **MOBILE PHONE #**_____

Check to receive statements/communications via email_____ **EMAIL**_____

ARE YOU CURRENTLY IN TREATMENT W/ANOTHER BEHAVIORAL HEALTH PROVIDER?_____

INSURANCE INFORMATION: PROVIDE COPY OF INS. CARD (FRONT AND BACK) COMPLETE ONLY SECTIONS NOT INCLUDED ON CARD

Name of person financially responsible for bill (Guarantor) if different: _____

GUARANTOR'S S.S.N._____**RELATIONSHIP TO PATIENT**_____

ADDRESS_____ **PHONE**_____

RESPONSIBLE PERSON'S EMPLOYER _____**WORK PHONE**_____

INSURANCE COMPANY (PRIMARY)_____**SUBSCRIBER**_____

INSURANCE CO. ADDRESS_____

POLICY NUMBER_____**GROUP NUMBER**_____

POLICY HOLDER DATE OF BIRTH_____**POLICY EFFECTIVE DATE** _____

INSURANCE COMPANY(SECONDARY)_____**SUBSCRIBER**_____

INSURANCE CO. ADDRESS_____

POLICY NUMBER_____**GROUP NUMBER**_____

POLICY HOLDER DATE OF BIRTH_____**POLICY EFFECTIVE DATE**_____

MEDICAL INFORMATION:

Name of Primary Care Physician: _____

PCP Address:_____**PCP Telephone Number**:_____

Current Medications:_____**Known Allergies**:_____

Name of Emergency Contact:_____**Emergency Contact Phone #:**_____

Relationship to Patient:_____

I give permission for my primary care physician to be notified of mental health treatment by this practitioner. I also have received information regarding Forest Clinical Services policies and procedures with this form.

Signature_____

To be Complete by Clinician DIAGNOSIS CODE (5 DIGIT NUMERICAL CODE) _____