Comprehensive
Counseling Services

Patient Registration

Patient Information

Patient Name: _____ Nickname: _____
Last First MI

Date of Birth: _____ Gender: Male Female Marital Status: S M W D Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____
Apt#

Patient: Home # _____ Cell # _____ Work # _____ Ext: _____

Employment Status: Full-Time Part-Time Student Other Employer's Name: _____

Emergency Contact (Name): _____ Phone #: _____

Relationship to patient: _____

Choose *one* type of appointment reminder you prefer:

☐ Email: Email Address _____

☐ Text (Requires Cell Phone Number): _____

☐ Phone Call (Requires Phone Number) _____

☐ None (No Reminder)

Billing Information

Responsible Party (who pays the bill?)

Name: _____ Phone #: _____
Last First MI

Social Security #: _____ Relationship to patient: _____

Billing Address: _____City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance Company: _____ Ins. Phone # _____

Insurance I.D. # _____ Group Number _____

Insured Name: _____ Date of Birth_____ Social Security # _____

Address: _____ City: _____State _____ Zip: _____
Apt #

Insured Phone # _____ Employer: _____

Secondary Insurance Company: _____ Ins. Phone # _____

Insurance I.D. # _____ Group Number _____

Insured Name: _____ Date of Birth_____ Social Security # _____

Address: _____ City: _____State _____ Zip: _____
Apt #

Insured Phone # _____ Employer: _____

The above information is correct and I give permission for the office to make appointment reminders as indicated above.

Patient/Guardian Signature _____***Date:*** _____