(Please Print)

CLIENT REGISTRATION SHEET

Today's Date:		

Primary Insured (REQUIRED)

Insured's Last Name :	***First:***	***Middle:***	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Email Address:	***Best contact #: Cell or Home*** ( )	***Social Security no.:***	***Birth Date:*** / /	***Sex:*** ❑ M ❑ F

Insurance Company:	Insurance Billing Address:	Insurance phone no.: (back of card) ( )

Policy/Subscriber/Member #	***Group no.:***	***Relationship to Insured:***	❑ Self	❑ Spouse	❑ Dependent

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insurance Company:	Insurance Billing Address:	Insurance phone no.: ( )

Policy/Subscriber/Member #	Group no.:	Relationship to Insured:	❑ Self	❑ Spouse	❑ Dependent

Client Information

Clients Last Name:	**First**:	**Middle:**	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Street Address:	***City/State/Zip code:***	***Email Address:***	***Drivers License:***

Home phone no.: ( )	Cell/Other contact no.: ( )	***Social Security no.:***	***Birth Date:*** / /	Sex: ❑ M ❑ F

Employer Name of Primary Insured (required for EAP):	**Occupation:**	**Work phone No:** ( )

Street Address:	City:	State:	ZIP Code:

Referring Doctor (if required by insurance):	

Notify Primary Care Physician? ❑ YES ❑ NO	Name of Primary Care Physician (TRI CARE Required)	Contact no.: ( )

IN CASE OF EMERGENCY

Emergency Contact Name:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinician. I understand that I am financially responsible for any balance. I also authorize ***Anew Family Counseling Center***, and/or those acting on the practice's behalf, and my insurance company to release any information required to process my claims.

Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

Client/Guardian signature	*Date*