COUNSELING REGISTRATION FORM

Diagnosis code: _____
Diagnosis code: _____

CLIENT INFORMATION	HEALTHCARE PROVIDERS
NAME:	PRIMARY PHYSICIAN:
ADDRESS:	PSYCHIATRIST:
	EMPLOYER
CITY:	NAME:
STATE: ZIP:	ADDRESS:
PHONE-HOME:	
PHONE-WORK/CELL:	CITY:
SOC. SEC. #:	STATE: ZIP:
DATE OF BIRTH: GENDER:	PHONE:
MARITAL STATUS: ETHNICITY:	OCCUPATION:
SPOUSE DATE OF BIRTH:	**INSURANCE COMPANY**
NEXT OF KIN OR PERSON TO NOTIFY	NAME:
NAME:	ADDRESS:
ADDRESS:	
	CITY:
CITY:	STATE: ZIP:
STATE: ZIP:	PHONE:
PHONE-HOME:	**POLICY HOLDER**
PHONE-WORK/CELL:	EMPLOYEE NAME:
RELATION TO CLIENT:	SOC. SEC. #:
AUTHORIZATION INFORMATION	DATE OF BIRTH:
AUTHORIZATION #:	RELATION TO CLIENT:
EFFECTIVE DATE:	EMPLOYER:
EXPIRATION DATE:	POLICY OR COVERAGE #:
# OF AUTH. VISITS:	GROUP NAME OR #: