FAMILY COUNSELING CENTER
REGISTRATION HISTORY

ABOUT THE CLIENT (ADULT OR CHILD)

Today's Date:_____

Client's Name:_____ **Birthdate**: _____

What do you prefer to be called:_____Previous Names _____

Social Security # _____ ___ Male ___Female

____ Minor ____ Single ____ Married ____ Divorced ____ Separated ____ Widowed

Street Address: _____

City _____ **State** _____ **Zip** _____ **Phone** #_____

Employer:_____ How Long Have You Worked There?_____

Employer Address:_____ **Work #:**_____

Spouse's Name:_____

Spouse's Birthdate:_____ Spouse's Social Security #_____

Whom may we thank for referring you:_____

Reason for Visit Today:_____

Previous Counseling?_____When:_____ Where:_____

CHILD INFORMATION (IF CLIENT IS A CHILD)

Child's School:_____ Child's Interests:_____

Name of person living with:_____ Relationship to child:_____

Who will be responsible for the account?_____

Biological or Adopted Father's Name_____Home Phone #_____

Address:_____ City_____ State _____ Zip _____

Father Employed By:_____ Employer's #_____

Father's Social Security #_____ Father's Birthdate:_____

Physical Custody _____ Yes _____ No **Legal Custody** _____ Yes _____ No

Biological or Adopted Mother's Name:_____ Home Phone #_____

Address:_____ City_____ State _____ Zip _____

Mother Employed By:_____ Employer's #_____

Mother's Social Security #_____ Mother's Birthdate:_____

Physical Custody _____ Yes _____ No **Legal Custody** _____ Yes _____ No

Other children in family(Names & Ages):

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

IN EVENT OF EMERGENCY

Whom should we contact:_____ Relationship to Patient?_____

Home Phone #_____ Work Phone #_____

PRIMARY INSURANCE INFORMATION

Insurance Company:_____ Phone#_____

Identification #_____ **Group or Plan** #_____

Primary Insured's Name:_____ **Relationship to Patient**:_____

Primary Insured's Birthdate _____ Social Security #_____

Insured's Employer:_____

SECONDARY INSURANCE INFORMATION

Insurance Company:_____ Phone#_____
Identification #_____ Group or Plan #_____
Primary Insured's Name:_____ **Relationship to Client**:_____
Primary Insured's Birthdate _____ Social Security #_____
Insured's Employer:_____

HEALTH HISTORY

Are you taking any medications?_____ If so, list them:_____
Date of last health care exam?_____ For What Reason?_____
Have you been hospitalized in the last 5 years?_____ If so, for what?_____
This form was completed by: _____
I have received a copy of the Notice of Privacy Practices.
I give consent to the treatment and assessment of me or my child.
No audio or videotaping of therapy sessions without prior written consent of the therapist and client.

Signature:_____Date:_____

READ AND SIGN THE FOLLOWING STATEMENTS

APPOINTMENT CONFIRMATION CALLS

I authorize Family Counseling Center to leave messages at the number listed on this form and to mail correspondence to the address listed on this form.

Date _____ Patient or Parent(if Minor):_____

****

RELEASE

I authorize the release of the following information to my insurance company which is necessary to process any claims for a time period not to exceed one year following the termination of service and will include only the following information: **DIAGNOSIS, NUMBER & DATES OF SESSIONS, TREATMENT STRATEGY.**

Date:_____ Patient or Parent(if minor):_____

ASSIGNMENT OF BENEFITS

I hereby authorize Family Counseling Center the medical benefits, if any, otherwise payable to me for the services to be regularly billed by The Family Counseling Center on my account. A Photocopy of this authorization may be honored.

Date:_____ Policyholder or Parent:_____

****

MEDICAL ASSISTANCE PATIENTS
RELEASE & GUARANTEE

I authorize the release of the following information to Medical Assistance which is necessary to process any claims for a time period not to exceed one year following the termination of service and will include only the following information: **DIAGNOSIS, NUMBER & DATES OF SESSIONS, TREATMENT STRATEGY.** I agree that if Medical Assistance does not pay for the charges incurred or to be incurred, that I will be responsible for the charges.

Date:_____ Patient or Parent (if minor):_____