Counseling Associates of Rockford

New Patient Registration Form

Section I: Patient Information **Date**_____

Name: _____ Email Add: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

☐ I authorize Counseling Associate to send automated calls and text messages to this cell phone number; (_____) _____
☐ I do not wish to receive automated calls and text messages. I understand I will not receive reminder calls of my appointments.

Date of Birth: _____ Social Security Number: _____ Gender: ☐ Male ☐ Female

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer: _____ ☐ FT ☐ PT School: _____

Spouse or Parent's Name: _____ Phone (_____)_____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone (_____) _____

Section II Responsible Party

Relationship to Patient: ☐ Self (if Self, skip to Section III) ☐ Spouse ☐ Parent ☐ Other

Name: _____ Relationship to Patient: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

Employer: _____ Work Phone: (_____) _____ SSN#: _____

Section III Insurance Information

---------- PLEASE BRING A COPY OF YOUR INSURANCE CARD(S) ----------

Name of Insured: _____ DOB: _____ Relationship to Patient: _____

SSN#: _____ Name of Employer: _____ Work Phone: (_____) _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Grp. #: _____ ID#: _____

Ins. Co. Address: _____ Ins. Co. Phone: (_____) _____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING -------

Name of Insured: _____ DOB: _____ Relationship to Patient: _____

SSN#: _____ Name of Employer: _____ Work Phone: (_____) _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Grp. #: _____ ID#: _____

Ins. Co. Address: _____ Ins. Co. Phone: (_____) _____