

CARRIE GREINER, LCSW
PATIENT REGISTRATION FORM- *MINOR*

(Please Print)

Today's Date:	Appt. With:	Whom may we thank for referring you?	
PATIENT INFORMATION			
Last Name, First Name, Middle Initial		Birth Date:	Sex: ☐ Other ☐ Male ☐ Female
Street Address	City	State	Zip Code Home Phone No.:
PHONE NO. WE MAY LEAVE A MESSAGE ABOUT PATIENT?			
MOTHER'S INFORMATION			
Last Name, First Name, Middle Initial		Birth Date:	Home Phone No.:
Street Address	City	State	Zip Code Cell Phone No.:
Employer's Name, Address and Work Phone			
FATHER'S INFORMATION			
Last Name, First Name, Middle Initial		Birth Date:	Home Phone No.:
Street Address	City	State	Zip Code Cell Phone No.:
Employer's Name, Address, and Work Phone			
PRIMARY INSURANCE INFORMATION			
Insured's Last Name, First Name, Middle Initial		Birth Date:	Social Security #
Insurance Company		Phone Number	
Insurance Billing Address:			
Policy No.:	Group no.:	Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent	
SECONDARY INSURANCE INFORMATION (IF APPLICABLE)			
Insured's Last Name, First Name, Middle Initial		Birth Date:	Social Security #
Insurance Company		Phone Number	
Insurance Billing Address:			
Policy No.:	Group no.:	Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent	
The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the doctor. I understand that I am financially responsible for any balance. I also authorize Carrie Greiner, LCSW, Dr. Kimberly A. Lemke, P.C, and SR and R Counseling Inc, and those acting on the practice's behalf and the insurance company to release any information required to process my claims. Furthermore, I have reviewed the Notice of Privacy Practices & the Professional Service Agreement provided. I fully understand and accept the terms of this practice.			
Signature of Patient (age 12 & older)		Date	
Guardian Signature		Date	