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Registration Form

Name: _____
Last First Middle (preferred to be called)

Home: _____
Number and Street (Apt. #) City State Zip

Phone: _____ _____
Primary Phone (messages? **Y N**) Secondary Phone (messages? **Y N**)

Email: _____

Age: _____ **Date of Birth:** _____/_____/_____ **Gender:** _____

Race/Ethnicity: _____ **Pronouns:** ___He/Him ___She/Her ___ They/Them ____ Other:_____

Relationship Status: ___ Single ___ Married ___ Committed Relationship ___Separated ___Divorced ___Widowed

Name of Spouse/Partner (if applicable): _____ **Lives with you? Y N**

Children (if applicable): Name(s) and age(s)_____

_____

Highest degree completed: __ High school/GED __ Associate's degree __ Bachelor's degree
__ Master's degree __Doctoral/Professional Degree

If Employed: _____ _____
Job Title Name of Employer

If Student: _____ _____
Degree Program Name of School

Primary Physician:_____
Name, city and state, phone number

Emergency Contact:_____ **Phone:**_____
Name and relationship to you

INSURANCE (Please complete regardless of your intention to file for coverage of services received here. Copy of card is required.)

Primary Policy: _____
Insurance Company Subscriber ID number Name and Date of Birth of Policy Holder

Secondary Policy: _____
Insurance Company Subscriber ID number Name and Date of Birth of Policy Holder

SIGNATURE (*By signing below, you agree that you have provided accurate and complete information.)*

_____ Date: _____
Patient Signature (or, if applicable, Parent/Legal Guardian)

_____
Printed Name