Grimaldi Counseling, Inc.

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ PCP_____

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	Zip	Social Security #	Home Phone No. ( )

Occupation	Employer	Employer Phone No. ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Other Family Members Seen Here _____

BILLING and INSURANCE INFORMATION

Person Responsible for Bill ❑ Same as Above Other:	Birth Date / /	Address (if different from above)	Home Phone No. ( ) Cell Phone No: ( )
Is this person a client here?	❑ Yes ❑ No		

Occupation	Employer:	Employer Phone No. ( )
	Employer Address:	

Are you covered by insurance? ❑ Yes ❑ No Insurance Company Name:

Insurance Plan Name or Program:	Address: City State: Zip:

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #

Person's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Person's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Grimaldi Counseling, Inc.. I understand that I am financially responsible for any balance. I also authorize Grimaldi Counseling, Inc. or insurance company to release any information required to process my claims.

X _____

CLIENT / GUARDIAN SIGNATURE DATE