Aimee O'Keefe. LCSW-R

PATIENT REGISTRATION FORM

PATIENT INFORMATION—PLEASE PRINT

Today's Date: _____ Phone: _____ Date of Birth: _____ Patient's Name: _____ Driver's License #: _____ Address (no PO Boxes please) _____ City _____ State:_____ Zip Code:_____ Sex: ☐ M ☐F Social Security # _____☐Single ☐ Married ☐ Divorced ☐Separated ☐ Widowed Patient's Employer _____ Employer Phone: _____ Business Address _____ Name of Person Responsible for Payment_____ Emergency Contact _____ Emergency Phone: _____

IF PATIENT IS A MINOR, COMPLETE THE FOLLOWING INFORMATION

Name of Person Completing Form _____ ☐ Mother ☐Father ☐ Legal Guardian

SECTION I

Mother/Guardian Name _____ Home Phone:_____ Address (no PO Boxes please) _____ City _____ State _____ Zip Code _____ Date of Birth:_____ Social Security # _____ Mother/Guardian Employer_____ Occupation_____ Business Address _____ Business Phone _____

SECTION II

Father/Guardian Name _____ Home Phone:_____ Address (no PO Boxes please) _____ City _____ State _____ Zip Code _____ Date of Birth:_____ Social Security # _____ Father/Guardian Employer_____ Occupation_____ Business Address _____ Business Phone _____ If Parents Single/Divorced, please indicate the following: ☐ Joint Legal Custody ☐ Custodial Parent _____

INSURANCE INFORMATION

Name of Insured _____ Insured's Social Security # _____ Insured's Date of Birth _____ Insured's Policy Number _____ Group Number _____

Relationship to Patient ☐Self☐Spouse ☐Parent ☐Parent ☐ Guardian ☐ Other_____
Insured's Address _____Business Phone _____ Employer's Address _____ Insurance Company Name _____ Insurance Company Address _____ City _____ State _____ Zip Code _____ Insurance Company Phone number _____ Effective Date of Coverage _____