

# PATIENT REGISTRATION FORM

Wendy Jensen, LCSW

Patient		(Please Print)	Today's Date	
<input type="checkbox"/> New	<input type="checkbox"/> Existing		/	/

## PATIENT INFORMATION

Last Name			First Name			Middle					
Home Address				Mailing Address							
City		State	Zip Code		City		State	Zip Code			
Gender	Date Of Birth		Age	Social Security Number			Marital Status (Circle One)				
<input type="checkbox"/> F <input type="checkbox"/> M	/ /						Single	Married	Divorced	Separated	Partnerd
Home Phone		Cell Phone		Email Address				Work Phone		Ext.	
( )		( )						( )			
<b>May we leave voicemail messages?</b>			<b>At Your Home:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>At Your Work:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No			

## IN CASE OF EMERGENCY

Emergency Contact		Home Phone		Work Phone		Ext.	Relationship To Patient	
		( )		( )				

## EMPLOYMENT INFORMATION

Employment Status										
<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Not Employed	<input type="checkbox"/> Active Military	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Retired	<input type="checkbox"/> Student	<input type="checkbox"/> Other:			
Occupation			Employer				Employer Phone			
							( )			
Employer Address					City		State	Zip Code		

## PHYSICIAN INFORMATION

Referring Physician					Primary Care Physician				

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

<b>Primary Insurance Company</b>			Group Number		Insurance Id. Number		Co-Pay		
Patient's Relationship To Subscriber:				<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other:		

## Subscriber Information

Last Name		First Name		Gender		Date Of Birth		Employer		
				<input type="checkbox"/> F <input type="checkbox"/> M		/ /				

(Continued On Other Side)

**INSURANCE INFORMATION**

**Second Insurance Company**

**Group Number**

**Insurance Id. Number**

**Co-Pay**

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Patient's Relationship To Subscriber:

Self

Spouse

Child

Other:

**Subscriber Information**

**Last Name**

**First Name**

**Gender**

**Date Of Birth**

**Employer**

		<input type="checkbox"/> F	<input type="checkbox"/> M	/ /	
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**FINANCIAL RESPONSIBILITY**

**(If other than patient)**

**Last Name**

**First Name**

**Middle**

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**Mailing Address**

**Home Phone**

**Work Phone**

	( )	( )
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**City**

**State**

**Zip Code**

**Relationship To Patient**

			<input type="checkbox"/> Parent	<input type="checkbox"/> Guardian	<input type="checkbox"/> Other:
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**REASON FOR SEEKING COUNSELING**

**FINANCIAL AGREEMENT — SIGNATURE REQUIRED**

I understand that I am financially responsible for all charges rendered by Wendy Jensen, LCSW whether or not they are covered by insurance. I hereby give lifetime authorization for payment of insurance benefits directly to Wendy Jensen, LCSW accounts. I acknowledge that I am solely responsible in securing the necessary **REFERRALS** from my **PRIMARY CARE PHYSICIAN**. In the event of default I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I have read the above FINANCIAL AGREEMENT and understand it.

**Signature**

**Date**

**Parent/Guardian Signature – If patient is a minor**

**Date**