



# Center for Family Guidance

## PATIENT REGISTRATION FORM

**\* For Office Use Only**

Account #:	
DX Code:	

(Please Print)

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	
Is this your legal name?	If not, what is your legal name?		(Former Name)		Birth Date	Age	Sex
<input type="checkbox"/> Yes	<input type="checkbox"/> No				/ /		<input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City	State	ZIP Code	Social Security	Home Phone No.	
						( )	
P.O. Box		City		State	ZIP Code		
Occupation		Employer			Employer Phone No.		
					( )		
Referral source (Please check one box)				Cell Phone No.		( )	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to Home/Work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Dr.	<input type="checkbox"/> Other		

### INSURANCE INFORMATION

**(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**

Guarantor	Birth Date	Address (if different)		Home Phone No.
	/ /			
Guarantor Social Security #				( )
Occupation	Employer	Employer Address		Employer Phone No.
				( )
Is this patient covered by insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Please indicate primary insurance				
Subscriber's Name	Subscriber's S.S. #	Birth Date	Group #	Policy #
		/ /		
Patient's Relationship to Subscriber	<input type="checkbox"/> Self	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of Secondary Insurance (if applicable)	Subscriber's Name		Group #	Policy #
Patient's Relationship to Subscriber	<input type="checkbox"/> Self	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

### IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No.	Work Phone No.
		( )	( )

The above information is true to the best of my knowledge. I authorize Center for Family Guidance to release any information necessary to process my claims for payment. I understand that my co-payment is due at the time of my appointment. I understand that I am responsible for the fees for the services provided and should my account become delinquent, I am responsible for any attorney or collections fees incurred due to collecting a debt.

**Failure to cancel an appointment 48 hours in advance may result in a fee. \_\_\_\_\_ please initial**

<b>X</b>		
	PATIENT/GUARDIAN SIGNATURE	DATE