Registration Form

Client's Name:____ Date of Birth:_______________
Gender (circle one): M F Social Security Number:____________________________
Address:____________________________________ City:_______________State:___________ Zip code:______
Home Phone:_____________________ Cell Phone:____________________ Work Phone:________________
Occupation:____________________________ Employer:________________________________
Address:________________________________City:_____________State:__________ Zip code:_________
Email:____
Marital Status (circle one): Single Married Separated Divorced
Spouse's Name: ____Date of Birth:_______________
Children in Family (names, ages, occupation):____
____

Primary Care Physician (PCP):__________________ Location:________________ Phone:_________

Current Medications:____
____

Reason for visit: ____
____

Emergency Contact:____________________________Relationship:_________Phone:___________

Insurance Information (please bring card & ID to visit)
Insurance Company:____________________________ Membership #:________________ Group #:
____
Subscriber's Full Name:__________________________ DOB Subscriber:_____________ Relationship to Subscriber:______
Complete box if client is minor:
Parent/Legal Guardian Name:____
Address:____ Phone:_________________
Occupation:______________________ Employer:_____________ Address:______________________
Phone:____________
Minor's School:____________________________________ Grade:___________________

I hereby authorize Mark L. Vander Ley, MC, LCPC, Connections Family Counseling, LLC to furnish information to insurance carriers, government agencies and/or third party billing entity concerning my illness and treatments and I hereby assign to them all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance.

Signature:______________________________________ Date:______________________