

## CLIENT REGISTRATION FORM

**Full Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Work Email:** \_\_\_\_\_

**Home Email:** \_\_\_\_\_

**Insurance Co. Name:** \_\_\_\_\_

**Insurance Co. Address (if other than BC/BS):** \_\_\_\_\_

\_\_\_\_\_

**Insurance Co. Phone (if other than BC/BS):**

**Policy #:** \_\_\_\_\_

**Group #:** \_\_\_\_\_

**Subscriber:** \_\_\_\_\_

**Subscriber's Date of Birth:** \_\_\_\_\_

**Patient's Date of Birth:** \_\_\_\_\_

**Patient's Employer:** \_\_\_\_\_

**Subscriber's Employer:** \_\_\_\_\_

**Co-insurance:** \_\_\_\_\_; **Number of visits / year:** \_\_\_\_\_; **Deductible:** \_\_\_\_\_

**PPO** Y / N (Circle One)

*The client is responsible for any deductibles, co-insurance payments or outstanding balances that your insurance does not cover.*

---