Disney Family Therapy

REGISTRATION FORM

(Please print)

Today's Date:	Therapist:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr.	☐ Miss	Marital Status:
Parents/Guardians:	☐ Mrs.	☐ Ms.	Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name?	If not what is your legal name?	(Former name):	Birth Date:	Age:	Sex:
☐ Yes ☐ No					☐ M ☐ F

Street Address:	Social Security Number:	Home phone Number: ( )

PO Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer's Phone Number: ( )

Chose clinic because/referred to clinic by (please check one box)	☐ Dr.	☐ Insurance Plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other (list)

Other family members seen here:

INSURANCE INFORMATION

Person responsible for bill:	Date of Birth:	Address (if different):	Home phone Number: ( )

Is this person a client here? ☐ Yes ☐ No

Occupation:	Employer:	Employer's Phone Number: ( )

Is this person covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐ [Insurance]	☐ [Insurance]	☐ [Insurance]	☐ [Insurance]	☐ [Insurance]

☐ [Insurance]	☐ [Insurance]	☐ [Insurance]	☐ Welfare (please provide coupon)	☐ Other

Subscriber's Name:	Subscriber's S.S number:	Birth Date:	Group number:	Policy number:	Co-Payment $

Patient's Relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable)	Subscriber's Name:	Group number:	Policy number:

Patient's Relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

EMERGENCY INFORMATION

Name of local friend or relative (not living in same address):	Relationship to patient:	Home phone number: ( )	Work Phone Number: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any balance. I also authorize Dsiney Family Therapy to release any information required to process my claims.

Patient/Guardian Signature:	*Date:*