Julie Hanson, LCSW

REGISTRATION FORM

(please print)

Today's Date:	Primary Care Physician

PATIENT INFORMATION

Patient's Last Name First Name Middle	☐ Mr ☐ Miss ☐ Mrs ☐ Ms	**Marital Status (circle one)** Single Married Divorced Separated Widowed Other

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name)	**Date of Birth**	**Age**	**Sex**
			/ /	____	☐ Male ☐ Female

Street Address:	Home Phone#	Cell Phone#
City:	State:	Zip
Email:	May I leave a message on one? ☐ Email ☐ Home Phone# ☐ Cell Phone #	

Emergency Contact:	Relationship to Patient:	Phone: Address:

Name of Parent or Guardian if patient is a minor or dependent: _____

Relationship to Client: _____ Phone: _____

Primary Concern for coming to counseling:

How were you referred to Julie Hanson, LCSW?

BILLING/INSURANCE INFORMATION

(A COPY OF YOUR INSURANCE CARD IS REQUIRED BEFORE ANY CLAIMS CAN BE FILED

Person responsible to bill:	DOB:	Address (if different):	Home/Cell Phone:

Is this patient covered by insurance? ☐ Yes ☐ No	Will this patient be self pay? ☐ Yes ☐ No

Name of Insurance Company:			Cardholder's Name: Address:
Insurance ID #:	Group #:	Copay: $	Relationship to Patient: Cardholder's DOB: / /

Occupation:	Employer:	Employer Phone #: