Cenla Professional Counseling, LLC
REGISTRATION FORM

Today's Date: _____ **PCP:** _____

CLIENT INFORMATION

Client's Last Name: _____ First: _____ Middle: _____

☐Mr. ☐Mrs. ☐Miss ☐Ms. Former Name (if applicable): _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Is this your legal name? ☐Y ☐N If not, what is your legal name? _____

DOB: _____ Age: _____ Sex: _____ SSN: _____

Street Address: _____ Cell Ph#: _____ Hm Ph#: _____

P.O. Box: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Student: ☐Full-time ☐Part-time

Employer: _____ Employer's Ph#: _____

Chose clinic because/Referred to clinic by: _____

Other family members seen here: _____

INSURANCE INFORMATON
(Please give insurance card to receptionist)

Person responsible for bill: _____ DOB: _____
Address (if different): _____ Home Ph#: _____
Is this person a patient here? ☐Y ☐N

PRIMARY INSURANCE: _____ ☐Private OR ☐Medicaid
Subscriber's Name: _____ Subscriber's SSN: _____ DOB: _____
Subscriber's Address: _____
Subscriber's ID or Policy #: _____ Group #: _____ Co-payment: _____
Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other: _____

SECONDARY INSURANCE (if applicable): _____ ☐Private OR ☐Medicaid
Subscriber's Name: _____ DOB: _____ Subscriber ID #: _____
Subscriber's Address: _____
Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other: _____

IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to patient: Phone #:

_____

☐ I give permission to Cenla Professional Counseling to communicate with my emergency contact(s) about appointment scheduling and reminders.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Cenla Professional Counseling or insurance company to release any information required to process my claims.

Patient/ Guardian signature: _____ Date: _____