

Fairhaven Counseling: Shirley Sprenger Lange, MA, LMHC REGISTRATION FORM

| Today's Date: | | | PCP: | | | | |
|--|----------------------------------|---|---------------------------------------|---|---|--|---|
| PATIENT INFORMATION | | | | | | | |
| Patient's last name: | | First: | Middle: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/> | |
| Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? | | (Former name): | | Birth date: | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Street address: | | | Social Security no.: | | Home phone no.: | | |
| P.O. box: | | City: | | State: | ZIP Code: | | |
| Occupation: | | Employer: | | | Employer phone no.: () | | |
| Chose clinic because/referred to clinic by.....? | | | <input type="checkbox"/> Dr. | | <input type="checkbox"/> Insurance plan | <input type="checkbox"/> Hospital | |
| <input type="checkbox"/> Family | <input type="checkbox"/> Friend | <input type="checkbox"/> Close to home/work | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Other | | | |
| Other family members seen here: | | | | | | | |

| INSURANCE INFORMATION | | | | | | |
|---|--|--|---------------------------------|--------------------------------|--------------------------------|------------------------|
| (Please give your insurance card to the therapist to copy.) | | | | | | |
| Person responsible for bill: | | Birth date: | Address (if different): | | Home phone no.: () | |
| Is this person a client here? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| Occupation: | | Employer: | Employer address: | | Employer phone no.: () | |
| Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| Please indicate primary insurance | | <input type="checkbox"/> [Insurance] | | Address: | | |
| Phone: | | <input type="checkbox"/> Welfare (Please provide coupon) | | | <input type="checkbox"/> Other | |
| Subscriber's name: | | Subscriber's S.S. no.: | | Birth date: | Group no.: | Policy no.: |
| Patient's relationship to subscriber: | | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other | |
| Name of secondary insurance (if applicable): | | Subscriber's name: | | | Group no.: | Policy no.: |
| Patient's relationship to subscriber: | | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other | |
| IN CASE OF EMERGENCY | | | | | | |
| Name of local friend or relative (not living at same address): | | | Relationship to patient: | | Home phone no.: () | Work phone no.: () |
| 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 Shirley S. Lange or Fairhaven Counseling to release any information required to process my claims. | | | | | | |
| Client signature | | | | Date | | |