REGISTRATION FORM

CLIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Dr. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Okay to call/text/email reminders? ❑ Yes ❑ No	Nickname:	Email address:	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:	Mobile phone: ( )	Home phone: ( )				
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone: ( )				
Referred by:						
If patient is a minor, names of parents:						

INSURANCE INFORMATION

Person responsible for payment of fees:	Birth date: / /	Address (if different):	Home phone: ( )		
Occupation:	Employer:	Employer address:	Employer phone: ( )		
Is this patient covered by Blue Cross/Blue Shield PPO? ❑ Yes ❑ No	If **yes**, please provide information below. If **no**, payment will be required at the time of service.				
Subscriber's name:	Effective date:	Birth date: / /	Group #:	Policy #:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ 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 clinician. I understand that I am financially responsible for any balance. I also authorize the Clinician or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

❑ Separate *Client Consent for Treatment Form*, signed by client or guardian, is required to initiate treatment.

True North Clinical Associates is a practice comprised of individually licensed and practicing clinicians.