REGISTRATION FORM

(Please Print)

Today's Date:	Provider: **Sue E. Coffey, LCSW, RPT-S**

PATIENT INFORMATION

Patient's name: **LAST:** **FIRST:**	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single☐ Mar☐ Div☐ Sep☐ Wid☐

Sex: M F	Birth date:	Age:

Street address:	Social Security no.:	

P.O. box:	City:	State:	ZIP Code:

Home Phone:	Cell Phone:	Work Phone:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the provider.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone :

Is this person a patient here?	☐ Yes	☐ No

Employer:	Primary Care Dr. :

Is this patient covered by insurance?	Yes	No	Dr. Phone #:

Please indicate primary insurance	Name of Insurance Co:

Subscriber's name:	Subscriber's Birth Date	Subscribers S S #:	Policy no.:	Group no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	Co- Pay $

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

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

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

_____ _____

Patient/Guardian signature *Date*

For office use only;

DSM _____Intake date (90801)_____Charge_____ Service_____