Edwina L. Reyes, MFT
Life Counseling Inc.

Registration Form

Client's Name:_____ Date of Birth:_____
Social Security Number:_____ Gender (circle one): M☐ F☐
Address:_____
City:_____ State:_____ Zipcode:_____
Home Phone:_____ Cell Phone:_____
Occupation:_____ Employer:_____
Address:_____ Work Phone:_____
Email:_____
Marital Status (circle one): Single☐ Married☐ Separated☐ Divorced☐
Spouse's Name:_____
Children in Family (names, ages, occupation):_____
_____
Primary Care Physician (PCP):_____ Phone:_____
Current Medications:_____
Reason for visit:_____
Referred by:_____ May I thank this person? Yes___ No___

Emergency Contact Name:_____ Relationship:_____
Address:_____ Phone:_____

Insurance Information (please bring card & ID to visit)
Medical Insurance Company:_____
Membership Number:_____ Group Number:_____
Subscriber's Full Name:_____ DOB Subscriber:_____
Relationship to Subscriber:_____

Secondary Insurance Company:_____
Membership Number:_____ Group Number:_____
Subscriber's Full Name:_____ DOB Subscriber:_____
Relationship to Subscriber:_____

Complete box if client is minor:

Parent/Legal Guardian Name:_____
Address:_____ Phone:_____
Occupation:_____ Employer:_____

Work Address:_____ Work Phone:_____
Minor's School:_____ Grade:_____

I hereby authorize Life Counseling Inc. to furnish information to insurance carriers, government agencies and/or third party billing entity concerning my illness and treatments and I hereby assign to them all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance.

Signature:_Type Full Name to Sign_ Date:_____