PATIENT REGISTRATION FORM

Wendy Jensen, LCSW

Patient	(Please Print)	Today's Date
❑ New ❑ Existing		/ /

PATIENT INFORMATION

Last Name	First Name	Middle

Home Address	Mailing Address

City	State	Zip Code	City	State	Zip Code

Gender	Date Of Birth	Age	Social Security Number	Marital Status (Circle One)
❑ F ❑ M	/ /			Single Married Divorced Separated Partnerd

Home Phone	Cell Phone	Email Address	Work Phone	Ext.
( )	( )		( )	

May we leave voicemail messages?	At Your Home:	❑ Yes ❑ No	At Your Work:	❑ Yes ❑ No

IN CASE OF EMERGENCY

Emergency Contact	Home Phone	Work Phone	Ext.	Relationship To Patient
	( )	( )		

EMPLOYMENT INFORMATION

Employment Status

❑ Full Time ❑ Part Time ❑ Not Employed ❑ Active Military ❑ Self Employed ❑ Retired ❑ Student ❑ Other:

Occupation	Employer	Employer Phone
		( )

Employer Address	City	State	Zip Code

PHYSICIAN INFORMATION

Referring Physician	Primary Care Physician

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Company	Group Number	Insurance Id. Number	Co-Pay

Patient's Relationship To Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

Subscriber Information

Last Name	First Name	Gender		Date Of Birth	Employer
		❑ F	❑ M	/ /	

(Continued On Other Side)

INSURANCE INFORMATION

Second Insurance Company	Group Number	Insurance Id. Number	Co-Pay

Patient's Relationship To Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

Subscriber Information

Last Name	First Name	Gender		Date Of Birth	Employer
		❑ F	❑ M	/ /	

FINANCIAL RESPONSIBILITY
(If other than patient)

Last Name	First Name	Middle

Mailing Address	Home Phone	Work Phone
	( )	( )

City	State	Zip Code	Relationship To Patient
			❑ Parent ❑ Guardian ❑ Other:

REASON FOR SEEKING COUNSELING

FINANCIAL AGREEMENT — SIGNATURE REQUIRED

I understand that I am financially responsible for all charges rendered by Wendy Jensen, LCSW whether or not they are covered by insurance. I hereby give lifetime authorization for payment of insurance benefits directly to Wendy Jensen, LCSW accounts. I acknowledge that I am solely responsible in securing the necessary **REFERRALS** from my **PRIMARY CARE PHYSICIAN**. In the event of default I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I have read the above FINANCIAL AGREEMENT and understand it.

Signature **Date**

Parent/Guardian Signature – If patient is a minor **Date**