REGISTRATION INFORMATION

PATIENT INFORMATION

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip

TELEPHONE: _____ /_____ Okay to leave message: Y N
Home Cell

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: Single ✔ Married ✔ Divorced ✔ Widowed ✔ STUDENT STATUS: Full-Time ✔ Part-Time ✔

EMPLOYMENT STATUS: Full-Time ✔ Part-Time ✔ Retired ✔ Not Employed Outside Home ✔

RESPONSIBLE PARTY INFORMATION

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip

TELEPHONE: _____ / _____ Okay to leave message: Y N ✔ ✔
Home Cell

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

EMPLOYER: _____

ADDRESS: _____
Street City State Zip

INSURANCE INFORMATION (Complete both if Primary/Secondary is part of Patient Coverage)

PRIMARY INSURANCE: _____

ADDRESS: _____

POLICY #: _____

GROUP #: _____ COVERAGE CODE: _____

SUBSCRIBER: _____

SUBSCRIBER D.O.B.: _____

SECONDARY INSURANCE: _____

ADDRESS: _____

POLICY #: _____

GROUP #: _____ COVERAGE CODE: _____

SUBSCRIBER: _____

SUBSCRIBER D.O.B.: _____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO THE BILLING AGENT OF EDEN COUNSELING, LLC, MY INSURANCE CARRIER(S) AND/OR THEIR AGENT(S) FOR PAYMENT OR DIRECT REIMBURSEMENT LESS ANY DEDUCTABLE OR CO-PAY I MAY OWE.

_____
Patient/Parent/Guardian Signature Date

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY

(CIRCLE ONE) Self ✔ Partner/Spouse ✔ Child ✔ Step-Child ✔ Foster-Child ✔ Grandchild ✔