Sioux Falls Wellness Counseling

REGISTRATION FORM

PATIENT INFORMATION				
Last Name:	First:	MI:	Marital Status:	Spouse's Name:
Address:	City:	State:	Zip:	
Birth Date:	Age:	Sex:		
Cell Phone:	Other Phone:			
Email:	Preferred way to contact:			
Occupation:	Employer:	Student: YES NO		
How did you hear about Sioux Falls Wellness? (circle all that apply): Website Family/Friend Referring Agency_____________ Other_____________				

PARENT/GUARDIAN (IF CLIENT IS A MINOR)		
Mother's Name:		
Address:	Cell Phone:	Other Phone:
Father's Name:		
Address:	Cell Phone:	Other Phone:
Guardian Name (If not a Parent):	Relationship:	
Address:	Cell Phone:	Other Phone:
Who has custody of client?		

BILLING INFORMATION (IF DIFFERENT FROM PATIENT)	
Person Responsible for Bill:	Address:
Phone #:	Is this patient covered by insurance?: YES NO

INSURANCE			
Insurance Name:	Group #:	Member ID:	Co-Pay:
Subscriber's Name:	Birth Date:	Subscriber Relationship:	

IN CASE OF EMERGENCY (NOT LIVING AT SAME ADDRESS)			
Name:	Relationship:	Cell Phone #:	Work Phone #:

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

Patient/Guardian Signature:	Date: