Therapist Name: _______________________ Date:____________

SOLUTION-BASED COUNSELING SERVICES, LLC

Client Registration

Welcome to our office. We are committed to providing the best, most comprehensive care available. Please assist us by providing the following information; all information is kept strictly confidential.
If you have questions or concerns, please ask.

PERSONAL CLIENT INFORMATION:

CLIENT NAME | DATE OF BIRTH | GENDER | AGE

HOME ADDRESS | CITY | STATE | ZIP

MAILING ADDRESS (IF DIFFERENT) | CITY | STATE | ZIP

HOME PHONE NUMBER | CELL PHONE NUMBER | WORK PHONE NUMBER

OCCUPATION | EMPLOYERS NAME

SPOUSES NAME | SPOUSES EMPLOYER (IF USING SPOUSE'S INSURANCE)

PARENT/GUARDIAN INFORMATION (IF CLIENT IS UNDER 18 YEARS OLD):

NAME OF PARENT/GUARDIAN | PHONE NUMBER

ADDRESS | CITY | STATE | ZIP

EMERGENCY CONTACT INFORMATION:

NAME OF EMERGENCY CONTACT | PHONE NUMBER | RELATION

ADDRESS | CITY | STATE | ZIP

PRIMARY INSURANCE:

INSURANCE COMPANY NAME | CUSTOMER SERVICE/BENEFITS PHONE NUMBER

SUBSCRIBERS FULL NAME | SUBSCRIBERS DATE OF BIRTH | SUBSCRIBERS SOCIAL SECURITY #

INSURANCE ID NUMBER | GROUP NUMBER

SECONDARY INSURANCE:

INSURANCE COMPANY NAME | CUSTOMER SERVICE/BENEFITS PHONE NUMBER

SUBSCRIBERS NAME | SUBSCRIBERS DATE OF BIRTH | SUBSCRIBERS SOCIAL SECURITY NO

INSURANCE ID NUMBER | GROUP NUMBER