New Transitions Counseling Center, Ltd.
415 South Creekside Drive, Suite 107
Palatine, IL 60074

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Client's **Last Name**:	**First:**	**Middle**:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security no.:	**Birth date:** / /	Age:	Sex: ❑ M ❑ F

Street address:		E-mail Address:	Home phone #: ( )
City:	State:	ZIP Code:	Cell phone #: ( )
Occupation:	Employer:		Work phone #: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital	
❑ Family	❑ Friend	❑ Website/Internet	❑ Yellow Pages	❑ Other

INSURANCE INFORMATION

(Please give your insurance card to the therapist.)

Person responsible for account:	Birth date: / /	Address (if different):	Home phone #: ( )
Occupation:	Employer:	Employer address:	Employer phone #: ( )

Is this patient covered by insurance? ❑ Yes ❑ No Self-Pay

Primary Insurance Company:					
Subscriber's Name:	Subscriber's S.S. no.:	**Birth date:** / /	**Group #:**	**Policy #:**	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Cell/Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to New Transitions Counseling Center, Ltd. I understand that I am financially responsible for any balance not paid by insurance. I also authorize New Transitions Counseling Center, Ltd. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*