******

***CLIENT REGISTRATION FORM***

**Name: Home Phone: ( )**

(Last) (First) (MI)

**Cell Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: Work Phone: ( )**

(Street or P.O. Box) (Apt. or Rt.)

**Race:**

(City) (State) (Zip) (Optional)

**Gender: M F DOB: \_\_\_/\_\_\_\_/\_\_\_\_\_ SS#: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**

**Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Drivers License Number:**

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer: Address:**

**Spouse’s Name: Employer: Phone#:**

Who is responsible for payment of services (if different from above)?

**Name: Relation to Client:**

(Last) (First) (MI)

**Address:**

(Street or P.O. Box) (Apt. or RT.) (City) (State) (Zip)

**Work Phone: ( ) Home Phone: ( ) SS#**

**Primary Insurance: Phone:**

**Insurance Company’s Address:**

**Primary Physician: Phone:**

**Insured’s Name: DOB: / / Gender: M or F**

**Insured’s ID# Group#:**

**Relationship to Client: Employer Plan: Yes No**

**Employer:**

**Emergency Contact:**

(Name) (Relation) (Phone #)

I authorize the release of Private Healthcare Information required, in the course of my services with Christopher Merrell M.A., L.P.C., to process third-party claims for benefits. I also release benefits for above services to be paid directly to Christopher R. Merrell M.A., L.P.C.

**Signature of Client or Responsible Party Date**