BRANDON AREA PSYCHOLOGY ASSOCIATES, LLC
www.brandonareapsychology.com

Client Registration Form

Welcome and thank you for choosing our office! In order to serve you properly, we need the following information to set up your clinical record. A copy of your driver's license, credit card, and insurance card (if applicable) will also be made if needed.

Date _____ **Client Name** _____ **Referred by** _____

SS#_____ **Administrative Sex ( ) Male ( ) Female** **Date of Birth** _____ **Age** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home # _____ **Cell #** _____ **Email** _____

Parent/Guardian Information (if applicable)

Mother's name _____ **Father's Name** _____

Mother's address _____ **Father's Address** _____

City _____ **State** _____ **Zip** _____ **City** _____ **State** _____ **Zip** _____

Home # _____ **Home #** _____

Cell # _____ **Cell #** _____

Email _____ **Email** _____

Responsible Party for Account

Person responsible for account _____ **Relationship to client** _____

Contact Information (if different from above) _____

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Primary Insurance Information (if applicable)

Name of Insured _____ **Relationship to client** _____

Date of Birth _____ **SS#** _____ **Name of employer** _____

Insurance Company _____ **Phone number** _____

Insurance Co. Address _____ **Effective date of current policy** _____

Policy Number _____ **Group Number** _____

Secondary Insurance Information (if applicable)

Name of Insured _____ **Relationship to client** _____

Date of Birth _____ **SS#** _____ **Name of employer** _____

Insurance Company _____ **Phone number** _____

Insurance Co. Address _____ **Effective date of current policy** _____

Policy Number _____ **Group Number** _____