Deborah Chavez, Ph.D., MFT

REGISTRATION FORM

CLIENT INFORMATION

Last Name_____First _____Middle_____

If your legal name or name on insurance card is different, what is it?_____

Address_____City, State, Zip_____

Home phone _____Cell_____Email_____do u text?_____

Birth date_____/___/_____Age_____Social Security Number _ _ _ -_ _- _ _ _ _ Sex____F____M

Marital Status _Single _Married _Separated _Divorced _Widowed

Employer_____Occupation_____

Your medical doctor?_____Who referred you?_____

IN CASE OF EMERGENCY

Name_____Relationship_____

Home Phone_____Cell_____Work _____

FOR CHILD CLIENTS ONLY

Biological Parents_____
Social Worker/Case Manager_____
Foster Parents/Guardian ad litem_____

School_____Grade_____Teacher(s)_____

MEDICAL INSURANCE INFORMATION

Person responsible for bill:
Last Name_____First_____Middle_____

Address_____City, State, Zip_____Social Security Number_____

Birth date____/_____/_____Home Phone_____Cell_____email_____

Employer_____Occupation_____City, State, Zip_____

Patient's relationship to subscriber: _____Self ____Child ____Spouse ____Other

Insurance Company_____**Policy #**_____**Group #**_____

Secondary Insurance (if any)
Insurance Company_____**Policy #**_____**Group #**_____

Last Name_____First_____Middle_____Birth date___/____/_____

Social Security Number _ _ _- _ _ - _ _ _ _ Patient's relationship to subscriber: _____Self ____Child ____Spouse ____Other

Office use only:
Authorization#_____DX_____Appointment date_____