Choices, Counseling and Coaching

Registration Information

Date: _____

Client Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Sex: M☐ F☐ Age: ____ Date of Birth: _____ Single☐ Married ☐

Employment: _____

Email address: _____

Whom may we thank for referring you: _____

In case of emergency, whom should be notified? _____ Phone: _____

Purpose of Visit: _____

Signature of Client: _____

If client is a minor, I consent for my minor child to be treated at Choices, Inc.

Signature of Parent: _____

_____

Insurance Company: _____ Address: _____

Policy Holder Name: _____ Date of Birth: _____

Employer Name and Address: _____

Phone: _____ Policy # _____ Group # _____

Person Responsible for Payment of this Account

Name: _____ Address: _____

Responsible Person's Signature: _____