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: ____

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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: ____