Elizabeth Pierce, Ph.D.
Licensed Psychologist

CLIENT REGISTRATION FORM

Date:_____ Referred by:_____

Patient Name:_____ Date of Birth:_____

(circle Parent 1: Mother/Father/Legal Guardian Name if child):_____

Address_____

City_____ State _____ Zip _____

Home Phone_____ Cell Phone _____ Work Phone_____

Patient Occupation_____ (Parent 1 Occupation if child) _____

(circle Parent 2: Mother/Father/Legal Guardian Name if child):_____

Address_____

City_____ State _____ Zip_____

Home Phone_____ Cell Phone _____ Work Phone_____

(Parent 2 Occupation if child) _____

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Physician/Pediatrician:_____Address:_____

Phone:_____

In case of emergency, please contact _____ Phone:_____

Relationship to patient:_____

If Using Insurance:

If insurance listed under different address from above, please list: _____

Insurance Company _____ Patient's ID #:_____

Policy Holder's (P.H.) Name:_____ P.H.'s Employer:_____

P.H.'s Address and Phone: _____P.H.'s Date of Birth: _____

Does **patient** have other insurance? Yes No Person responsible for bills _____

OVER>

Email Addresses:

Patient:_____

Parent 1:_____

Parent 2: _____