Elizabeth Pierce, Ph.D.
Licensed Psychologist

CLIENT REGISTRATION FORM (ADULT)

Date:_____________________________ Referred by:__________________________________

Patient Name:___________________________________ Date of Birth:____________________

Address____

City______________________________ State ____________________ Zip ______________

Home Phone____________________ Cell Phone ____________________ Work Phone__________________

Patient Occupation____

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PCP Name:______________________________________Address:________________________________

__________________________Phone:__________________________

In case of emergency, please contact __________________________ Phone:_____________________

Relationship to patient:______________________________

If Using Insurance:

If insurance is 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 _________________________

Patient Email Address: ____