REGISTRATION INFORMATION
(PLEASE PRINT)

Date____________________________ Home Phone___________________

Client____ Cell Phone___________________
Last Name First Name Initial

Responsible Party (if minor)____

Street Address____ Email___________________________

City____ State______________ Zip____________________________

Sex * M * F Age________________ Birthdate__________________

* Married * Widowed * Single * Minor* Separated * Divorced

* Partnered for______years

Client Employer/School____ Occupation_______________

Spouse (or responsible party) Employed by________________________________ Occupation_______________

Purpose of visit____

Who is responsible for this account?____________________ Relationship to client___________________________

Social Security #____________________________________ Spouse's Social Security #_____________________

Do you have insurance? * Yes * No If yes,

Name of Primary Insurer____

Contract #_______________________ Group #___________________ Subscriber #___________________________

Name of Secondary Insurer (if any)____

Contract #_______________________ Group #___________________ Subscriber #___________________________

* Medicare * Medicaid Claim #_________________________________

If Welfare, your number_____________________________________ County of____________________________

In case of emergency, who should be notified?______________________________ Phone____________________

How did you learn of our practice?____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with____
and assign directly to **Sophia Center, Inc.** all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions.

The above named Sophia Center may use my information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ___________________________
Signature of Client or Personal Representative Date

____ ___________________________
Please print name of Client, Parent, Guardian or Personal Representative Relationship to Client