VINE
COUNSELING CENTER

PATIENT REGISTRATION INFORMATION (ADULT)				
Last Name:	First:	MI	Birthdate:	Gender:
Home Address:			City:	
State:	Zip:	Home Phone: ( )		
Email:	Therapy Type(s): □ individual □ family □ group			

EMERGENCY CONTACT INFORMATION	
Name:	Relationship to Patient:
Home Phone:	Cell Phone:

REFERRING / PRIMARY CARE PHYSICIAN INFORMATION			
Last Name:	First:	Phone:	
Address:	State:	Zip:	

PRIMARY INSURANCE COMPANY INFORMATION			
Insurance Company Name:	Identification Number:		
Group Number:	Insurance Co. Phone:		
Billing Address:	City:	State:	
Policy Holder:	DOB:		
Address (if different than patient):			
City: Zip:	State:		
Relationship to patient: □ self □ spouse □ dependent			
Employer Name (of policy holder):	Occupation:		
Work Address:			
City: Zip:	State:		

SECONDARY INSURANCE COMPANY INFORMATION (if applicable)			
Insurance Company Name:	Identification Number:		
Group Number:	Insurance Co. Phone:		
Billing Address:	City:	State:	
Policy Holder:	DOB:		
Address (if different than patient):			
City: Zip:	State:		
Relationship to patient: : □ self □ spouse □ dependent			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Vine Counseling Center, those acting on the practice's behalf, and my insurance company to release any information required to process my claims. As the responsible party, I agree that providing this information is in no way guarantee of payment.

Responsible party signature: **Date:**

OFFICE USE ONLY -- DX CODE: _____