



PATIENT REGISTRATION INFORMATION – CHILD/ADOLESCENT				
Last Name:	First:	MI	Birthdate:	Gender:
Home Address:			City:	
State:	Zip:	Home Phone: ()		
Email:		Therapy Type(s): <input type="checkbox"/> individual <input type="checkbox"/> family <input type="checkbox"/> group		
PARENT INFORMATION				
Mother's Last Name:		First Name:		
Mother's Cell Phone:		Work/Alternate Phone:		
Father's Last Name:		First Name:		
Father's Cell Phone:		Work/Alternate Phone:		
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:		State:	Zip:	
Relationship to patient: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> dependent				
Employer Name (of policy holder):			Occupation:	
Work Address:				
City:		State:	Zip:	
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:		State:	Zip:	
Relationship to patient: : <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> 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: _____
