COUNSELING AND COPING STRATEGIES, LLC

REGISTRATION FORM

(Please Print)

Today's Date:____

Patient Name:____

Marital Status: Single______Widowed______Divorced______Separated______Married______

Social Security #____________________Date of Birth :_____________Gender: M/F___________

Address:____

Home Phone:_______________________Cell Phone:______________________________________

Email Address:____

Employer:____

Employer Address:____

Spouse's Name:____

Address:____

Cell Phone:_______________________Email Address:_____________________________________

Emergency Contact Name:___________________________Cell Phone:______________________

Address:_____________________________Email Address:_________________________________

Relationship to Patient: Self _______Spouse_______Child_______Parent_______Other_______

Medicare Insurance and #:____

Medical Insurance and #:____

Secondary Medical Insurance and #:____

Primary Care Physician and Phone Number:____

Psychiatrist or Neurologist Name and Phone Number: __________________________________

(If applicable)

Please present a photo ID and your insurance cards for your first appointment.

Please bring a list of your medications including any supplements you may take.